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OVERSIGHT ON ACTIVITIES OF THE VA'S INSPECTOR GENERAL

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

JUNE 11, 1980

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OVERSIGHT ON ACTIVITIES OF THE VA'S INSPECTOR GENERAL

WEDNESDAY, JUNE 11, 1980

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m., in room 412, Russell Office Building, Hon. Alan Cranston (chairman) presiding.

Present: Senators Alan Cranston, Robert T. Stafford, and Strom Thurmond.

OPENING STATEMENT OF HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman CRANSTON. The hearing will come to order.

This morning the Committee on Veterans' Affairs will conduct an oversight hearing regarding the progress and activities of the VA's Inspector General, Mr. Allan L. Reynolds, during his first full year in this statutorily created office.

This committee is very concerned about instances or allegations of fraud, waste, or mismanagement within the VA. Especially in these very austere fiscal times, any fraud, waste, or mismanagement is a particularly unacceptable burden on the Nation's taxpayers and a threat to the integrity of veterans' programs and the quality of health care and other services to which our Nation's veterans are entitled.

The committee is equally concerned that proper audit and investigative functions are performed in order to improve and assure the efficiency and effectiveness of the numerous programs administered by the VA. Thus, the committee attaches great importance to the activities of the VA's Inspector General and we intend, through this hearing, to review several aspects of the operations and functioning of that office in order to determine how well it is achieving its intended purposes.

Also, we will focus on the seven specific challenges that I posed and which Mr. Reynolds accepted at his confirmation hearing on the 5th of April last year and will explore certain aspects of the functioning of the Inspector General Office and the working relationships between that office and various departments within the VA.

The Inspector General Act of 1978, Public Law 95-452, was designed to improve the economy and efficiency of executive branch operations by establishing independent offices of inspectors general within various governmental departments and agencies, including the VA.

However, in the year prior to the enactment of Public Law 95-452, the Administrator of Veterans' Affairs had the foresight and concern to establish a VA Inspector General Office by administrative action. Since the Inspector General concept has either by administrative action or by statute existed in the VA for more than 2 years, I believe that many of the shakedown difficulties that must be expected in the staffing and operation of such an office and its relationship with other offices and entities should be resolved—or be well on the way to resolution—by this time.

We will be reviewing the testimony today to see if this has indeed occurred and to the extent that problems persist, to determine what steps are being taken to resolve them swiftly and effectively.

This morning I also intend to seek firm assurances that, in keeping with the congressional intent underlying the Inspector General Act of 1978, the independence, objectivity, and integrity of the Office of Inspector General within the VA is being maintained and to assure that it is carrying out its statutorily mandated duties in accordance with congressional intent.

Mr. Reynolds, it appears from your May 5, 1980, report on your accomplishments with respect to the challenges which I gave and you accepted at your confirmation hearing, as well as the two semiannual reports that you submitted pursuant to section 5(a) of the Inspector General Act, that you have made a definite impact in many areas but have fallen short of the mark in regard to certain specific challenges.

At this point, I would take particular note of the continuing high rates of overpayments of VA benefits and the level of outstanding debts that VA beneficiaries continue to owe to the VA—they are close to where they were last year.

As you recall, these were a very high priority with this committee last year and they continue to be a matter of great concern. Thus, the relative lack of progress there is a matter of keen disappointment to me and others on the committee, I am sure, as is the fact that the total dollars in defaulted education loans have more than tripled.

On a more positive note, I am pleased to observe that you came very close to meeting the challenge of auditing one-third of the VA medical centers. However, the committee has received several complaints over the past year about some of the procedures followed by your personnel in conducting such audits.

In some instances, it appears that excessive friction and controversy have developed between your office on the one hand and the VA's Department of Medicine and Surgery and affiliated medical schools on the other hand. Today, we will hear testimony about this situation and the committee is especially interested in learning of any plans that you and D.M. & S. may have to alleviate these problems in order to assure that the highest possible quality of health-care services are provided with the greatest possible efficiency and economy.

We look forward now to hearing your testimony, Mr. Reynolds, and that of the other witnesses. We have much ground to cover this morning. Thus, I request that each witness summarize his or her remarks so that we will have time to ask the many questions

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that I as well as other committee members have. I thank you very much.

First, we will have a statement by Senator Stafford. Bob.

Senator STAFFORD. Thank you, Mr. Chairman.

I commend the chairman for scheduling this oversight hearing concerning activities of the Office of the Inspector General of the Veterans' Administration. It is most appropriate that this committee from time to time exercise its oversight responsibilities, especially relating to the auditing and investigative arm of the agency over which we have jurisdiction.

The operations of the Veterans' Administration, unlike those of some governmental agencies which have come under public attention, are not and have not been bothered by fraud, abuse, or mismanagement. Nevertheless, it is the statutory responsibility of the Inspector General to coordinate auditing and investigating efforts and policy initiatives designed to combat fraud, abuse, and waste, and to promote efficiency and effectiveness of program operation within the Veterans' Administration.

It is our committee's responsibility to receive and evaluate the reports of such audits and investigations and to be satisfied that the purposes of the legislation authorizing the Inspector General's office are fulfulled.

I join in welcoming all of the witnesses who are with us in this hearing. Although other committees demand my attendance this morning, I assure you that careful attention and consideration will be given to your statements and testimony received at this hearing.

Chairman CRANSTON. Thank you, Bob.

Strom, do you have an opening statement?

Senator THURMOND. Thank you, Mr. Chairman.

Mr. Chairman, today the Senate Committee on Veterans' Affairs will hear testimony concerning the progress of the Office of Inspector General of the Veterans' Administration.

The Inspector General, Allan Reynolds, was confirmed by the Senate in April of last year and has been very active in conducting audits of and investigations into many aspects of the VA. The area of education overpayments and defaults within the education loan program is of great concern to me and, I am sure, all members of this committee. Last year it was reported that over $400 million in education overpayments had been made by the VA and over $8 million in education loans were in default. Although limited success has been made in the area of recouping overpayments, and the default rate has risen, I urge the Inspector General to continue his efforts in this area.

Mr. Chairman, I commend the Inspector General for the extensive work that has been done in auditing practically every major program of VA. However, I am concerned that unfavorable reports have been received from the field that relate to the heavyhanded procedures used while conducting these audits and investigations. I hope that the zeal with which these activities are conducted will be tempered in an effort to minimize internal problems and maximize the efficiency of the VA.

Mr. Chairman, I believe a policy of good internal auditing is essential for every agency and department of the Federal Government. It is imperative that a strict account of the taxpayers' money

be rendered if any agency can maintain its credibility. Also, where fraud, misuse of funds, and other illegal acts are discovered, I believe swift prosecution will serve as a deterrent to any such acts in the future.

Mr. Chairman, we have a distinguished list of witnesses today, and I look forward to their testimony.

Chairman CRANSTON. Thank you, Strom.

You may proceed, Mr. Reynolds.

TESTIMONY OF ALLAN L. REYNOLDS, INSPECTOR GENERAL, VETERANS' ADMINISTRATION, ACCOMPANIED BY WALLACE E. BUSBEE, ASSISTANT INSPECTOR GENERAL FOR AUDITING; AND WILLIAM L. RETTEW, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS

Mr. REYNOLDS. Thank you, Mr. Chairman.

Mr. Chairman, members of the committee, I welcome this opportunity to appear before the committee to review the progress and accomplishments of the Office of the Inspector General. I am accompanied by Mr. Wallace E. Busbee, Assistant Inspector General for Auditing and Mr. William L. Rettew, Assistant Inspector General for Investigations.

On May 5, 1980, I submitted a report to the committee on our efforts to meet the seven challenges you gave me, Mr. Chairman, at my confirmation hearing in April 1979. The following part of my statement summarizes our progress in meeting these challenges and, where appropriate, provides an update of additional progress of the past few weeks.

In the accounts receivable area which was the first challenge, we were to obtain a 50-percent reduction in accounts receivable by March 31, 1980. Numerous actions have been taken and others are in progress as the result of our audits and initiatives by responsible VA program and staff officials.

During the 12-month period ending March 31, 1980, accounts receivable adjusted for accounts for which VA can take or need take no further action, that is, accounts referred to the Department of Justice for collection and accounts which are in a repayment status, declined 4.5 percent which is far short of 50 percent. If no adjustments are made, the total accounts receivable increased by 7.5 percent for that 12-month period.

The decline in the adjusted balance of education accounts receivable, which are the majority of accounts receivable—65 percent—has been almost 14.5 percent. It is in this area that we have concentrated most of our efforts.

There will be a further reduction in the balance of accounts receivable as the result of initiatives which have been taken, additional ones we are recommending and new authorities which are currently in the legislative process. However, I doubt that these will produce a reduction of 50 percent in less than 2 years and it could take a good while longer.

Some of the additional initiatives being considered will require extensive and time-consuming changes to computer systems in order to accommodate such proposed changes as the charging of interest. Also, progress toward a reduction of 50 percent depends heavily on the availability of personnel to pursue more aggressive

collection efforts and, in my opinion, the enactment of authorities which permit use of IRS addresses for certain debt collection purposes and offset of accounts receivable against tax refunds.

Defaults on education loans rose from $7 million to $23.5 million during the year and the cumulative amount in default was 56.3 percent of matured loans. This default rate does not show signs of declining. In fact, it may yet go higher. We are developing recommendations to strengthen collection procedure.

The second challenge was to reduce the error rate in pension benefits 50 percent by March 31, 1980, and identify further actions needed. As explained in my report to the committee, information does not exist to measure the current error rate.

The results of a pretest of a new system to collect such information are currently being analyzed by us for indications of the causes for errors and actions which might be taken to correct such causes. However, neither the sample size nor methodology of pretest permits a determination of error rates. Partial implementation of the new system is scheduled for this fall with full implementation planned for next year. We will monitor the results.

The third challenge was to complete audits of half of the health manpower training grants by March 31, 1980. We have obtained audits of 55 percent of the costs charged to these grants as of June 30, 1979. Additional audits are in process and more will be obtained. Eventually, most of the costs will be audited as part of routine cyclical audits of the grantee institutions by the Federal audit agency responsible for these audits.

The fourth challenge was to audit one-third—54—of the VA medical centers by March 31, 1980, with particular attention to security, medication handling, patient records, and patient abuse. We completed audits of 51 medical centers—95 percent of the goal.

In addition, we conducted highly targeted audits at 93 medical centers for the purpose of reviewing specific problems which came to our attention through audit work at other locations, through complaints received over the employee hotline and from other sources, including Congress, and as the result of analyzing trends and vulnerabilities.

My report to the committee details the results of these efforts.

The fifth challenge was to reduce underutilization of specialized medical programs by promoting sharing of resources within the Federal Government and with the community. We approached this goal by means of an overall analysis of the barriers to sharing and an emphasis, during our medical center audits, on identifying underutilized specialized medical programs and recommending corrective actions.

There are some legal barriers to sharing. Although we have not yet reviewed it, we understand recently proposed legislation—S. 2613—is intended to encourage interagency cooperation by removing obstacles to sharing and requiring agencies to design and implement sharing arrangements.

The problem of underutilization of specialized medical programs was identified in 22 of 51 medical center audits where one or more specialized medical programs were found to be below utilization standards established by the Department of Medicine and Surgery.

To the extent sufficient time elapsed after our audits to determine utilization trends, we found a generally favorable picture. We will continue to monitor the trends of underutilized units identified in prior audits and give emphasis to this area in future audits.

The sixth challenge was to put remedial measures in place by June 30, 1979, to minimize the types of frauds which our investigations have identified in the home loan guaranty program. The implementation of major new procedures we suggested was accomplished within 5 months of the target date.

We believe the actions taken should provide an enhanced capability to prevent and detect fraud. We will continue to monitor the effective use of these procedures and other controls.

The seventh challenge was to continue close monitoring of target implementation with particular attention to protection against fraud, error, and unauthorized disclosure. Target is an on-line computer system estimated to cost $81.5 million, which on a phased basis is being installed to replace existing VA compensation, pension, and education automated systems.

During the past year, we completed four audits which specifically addressed the adequacy of controls against unauthorized access and disclosure in violation of beneficiaries' rights to privacy. We believe at this stage of system implementation, appropriate and adequate steps have been taken to protect these rights.

We also completed two audits which addressed the adequacy of risk analysis studies performed by program, ADP and contractor staffs. The purpose of these risk analysis studies is to determine the vulnerability of systems and hardware to a broad range of risks such as natural disaster, sabotage, fraud, misuse, et cetera, and to determine cost-effective means to reduce these risks to a tolerable level.

In addition to addressing the foregoing challenges, we have carried out a large number of other audit, investigative, and vulnerability assessment activities during the year. The scope and results of these activities are reported in my semiannual reports which have been provided to the committee.

I might point out that those reports total up in quantifiable dollar savings for the year period of about $37 million, which were either cost recoveries or cost avoidance, and that amount does not include some of our recommendations which have downstream impacts, such as the recommendation to use mail intercept which shows a potential reduction in over-payments of over $49 million.

I would like to emphasize that the progress in addressing these seven challenges as well as the total scope of our activities could not have been obtained without the support of this and other committees of Congress, the Administrator and others in the Veterans' Administration, and my staff of auditors, investigators, and analysts.

To elaborate on my staff capability, I currently have 298 auditors, investigators, analysts, and other professionals, 10 administrative personnel and 45 secretarial/clerical staff. The directors of my headquarters and field offices have many years of auditing or investigating experience in the Veterans' Administration. For audit supervisors and seniors in charge of major audits, 46 percent have 30 months or more of VA audit experience.

I have also attached information at the suggestion of the committee staff, comparing our resource capabilities and needs. The greatest need is restoration of the capability to perform more frequent audits of VA facilities.

Mr. Chairman, I would like to comment on only one other matter as a part of this statement. There have been certain allegations and criticisms made against me personally and members of my staff. Some of these were valid—not the ones against me personally, sir. [Laughter.]

Some of these were valid and we promptly took corrective action. Others are legitimate expressions of those with differing points of view. We recognize, however, that there are persistent concerns in the medical community over the operation of my office. There are two kinds of criticisms that I would like to address in particular.

One kind is based on erroneous perceptions of accepted and authorized procedures for the conduct of audits and investigations. Were I to accede to the procedures suggested by such critics, I would be abdicating certain of the responsibilities entrusted to me and seriously weaken our ability to carry out the intent of the Inspector General Act of 1978.

Another group of allegations is lacking in factual basis but is accepted as valid and repeated by third parties who have no firsthand knowledge of the true facts. The efficiency and effectiveness of our operation has been impacted by these allegations and criticisms.

I have had little opportunity to present the facts in response to these allegations to the medical community in particular at conventions, staff meetings, and other forums where such allegations and criticisms are discussed.

I am, therefore, very hopeful that this hearing will provide the opportunity to explore some of the allegations and complaints, to dispel those which are inaccurate, and to identify corrective actions which have been or should be taken to resolve legitimate problems in my operations.

I recognize, of course, that my operations are not perfect and that errors do occur. It has been my policy that all serious allegations of irregular conduct by auditors and investigators are to be promptly investigated by senior people on my staff. In addition, we are constantly aware of our need to supervise and train our staff in the proper conduct of audits and investigations.

Mr. Chairman, that concludes my prepared statement. I will be pleased, of course, to answer questions from the committee.

Chairman CRANSTON. Thank you very, very much.

[The prepared statement of Allan L. Reynolds and his response to written questions submitted by Hon. Alan Cranston, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF ALLAN L. REYNOLDS, INSPECTOR GENERAL, VETERANS' ADMINISTRATION

Mr. Chairman and members of the committee: I welcome this opportunity to appear before the Committee to review the progress and accomplishments of the Office of the Inspector General. I am accompanied by Mr. Wallace F. Busbee, Assistant Inspector General for Auditing, and Mr. William L. Rettew, Assistant Inspector General for Investigations.

On May 5, 1980, I submitted a report to the Committee on our efforts to meet the seven challenges you gave me, Mr. Chairman, at my confirmation hearing in April

1979. The following part of my statement summarizes our progress in meeting these challenges and, where appropriate, provides an update of additional progress of the past few weeks

ACCOUNTS RECEIVABLE

The first challenge was to obtain a 50 percent reduction in accounts receivable by March 31, 1980. Numerous actions have been taken and others are in progress as the result of our audits and initiatives by responsible VA program and staff officials. During the 12-month period ending March 31, 1980, accounts receivable adjusted for accounts for which VA can take or need take no further action (i.e., accounts referred to the Department of Justice for collection and accounts which are in a repayment status) declined 4.5 percent. If no adjustments are made, the total accounts receivable increased by 7.5 percent for that 12-month period. The decline in the adjusted balance of education accounts receivable, which are the majority of accounts receivable (65 percent) has been almost 14.5 percent. It is in this area that we have concentrated most of our efforts.

There will be a further reduction in the balance of accounts receivable as the result of initiatives which have been taken, additional ones we are recommending, and new authorities which are currently in the legislative process. However, I doubt that these will produce a reduction of 50 percent in less than two years and it could take a good while longer. Some of the additional initiatives being considered will require extensive and time-consuming changes to computer systems in order to accommodate such proposed changes as the charging of interest. Also, progress towards a reduction of 50 percent depends heavily on the availability of personnel to pursue more aggressive collection efforts and, in my opinion, the enactment of authorities which permit use of IRS addresses for certain debt collection purposes and offset of accounts receivable against tax refunds.

We have made further progress on two reviews which were only partially done at the time I submitted the May 5 report. In that report we showed the results of our analysis of the causes for education overpayments, but we indicated that practical solutions had not yet been identified for those problems which were causing 78 percent of these overpayments. We believe we have now identified a partial solution, primarily by establishing a simple means for beneficiaries to report changes in their status on a monthly basis. Our proposals are currently being reviewed by appropriate program officials.

We have completed our review of the education loan program. Defaults on education loans rose from $7 million to $23.5 million during the year and the cumulative amount in default was 56.3 percent of matured loans. This default rate does not show signs of declining. In fact, it may yet go higher. We are developing recommendations to strengthen collection procedure.

PENSION SYSTEM

The second challenge was to reduce the error rate in pension benefits 50 percent by March 31, 1980 and identify further actions needed. As explained in my report to the Committee, information does not exist to measure the current error rate. The results of a pretest of a new system to collect such information are currently being analyzed by us for indications of the causes for errors and actions which might be taken to correct such causes. However, neither the sample size nor methodology of pretest permits a determination of error rates. Partial implementation of the new system is scheduled for this fall with full implementation planned for next year. We will monitor the results.

GRANTS FOR HEALTH MANPOWER TRAINING

The third challenge was to complete audits of half of the health manpower training grants by March 31, 1980. We have obtained audits of 55 percent of the costs charged to these grants as of June 30, 1979. Additional audits are in process and more will be obtained. Eventually, most of the costs will be audited as part of routine cyclical audits of the grantee institutions by the Federal Audit Agency responsible for these audits.

AUDITS OF VA MEDICAL CENTERS

The fourth challenge was to audit one-third (54) of the VA medical centers by March 31, 1980 with particular attention to security, medication handling, patient records and patient abuse. We completed audits of 51 medical centers—95 percent of the goal. In addition, we conducted highly targeted audits at 93 medical centers for the purpose of reviewing specific problems which came to our attention through audit work at other locations, through complaints received over the employee hot-

line and from other sources including Congress, and as the result of analyzing trends and vulnerabilities.

My report to the Committee details the results of these efforts. The following updates the status of those reports identified as in process at the time of my report:

(1) Vulnerability assessment of medication handling. This assessment has been completed and the report issued.

(2) Summary audit report on quality controls for patient care. A draft report has been prepared and submitted to program officials for review and comment.

(3) Investigation of alleged patient abuse at VAMC, WACO. The investigative report and our recommendations for appropriate actions have been issued.

(4) Audit of educational TV. We have met with the Chief Medical Director and believe a satisfactory resolution has been obtained as to the approach for dismantling the appropriate amount of closed circuit television capabilities at medical centers and establishing necessary production centers.

(5) Eligibility for non-service-connected medical care. Consistent with our audit recommendations, the Deputy Administrator has directed collection action be instituted against VA employees who have abused the system.

(6) Vulnerability assessment of time and attendance reporting by part-time physicians. GAO has approved procedures which we suggested for tightening up the system to overcome the potential for fraud and abuse. These procedures are being developed for implementation.

(7) Recommendations for clarifying and strengthening ADP guidance. This report was completed and submitted to the Administrator who accepted all recommendations and directed their expeditious implementation.

SPECIALIZED MEDICAL PROGRAMS

The fifth challenge was to reduce underutilization of specialized medical programs by promoting sharing of resources within the Federal Government and with the community. We approached this goal by means of an overall analysis of the barriers to sharing and an emphasis, during our medical center audits, on identifying underutilized specialized medical programs and recommending corrective actions.

There are some legal barriers to sharing. Although we have not yet reviewed it, we understand recently proposed legislation (S. 2613) is intended to encourage interagency cooperation by removing obstacles to sharing and requiring agencies to design and implement sharing arrangements.

The problem of underutilization of specialized medical programs was identified in 22 of 51 medical center audits where one or more specialized medical programs were found to be below utilization standards established by the Department of Medicine and Surgery. To the extent sufficient time elapsed after our audits to determine utilization trends, we found a generally favorable picture. We will continue to monitor the trends of underutilized units identified in prior audits and to give emphasis to this area in future audits.

LOAN GUARANTY PROGRAM

The sixth challenge was to put remedial measures in place by June 30, 1979 to minimize the types of frauds which our investigations have identified in the home loan guaranty program. The implementation of major new procedures we suggested was accomplished within 5 months of the target date. We believe the actions taken should provide an enhanced capability to prevent and detect fraud. We will continue to monitor the effective use of these procedures and other controls.

We have been working with the Inspector General of the Department of Housing and Urban Development to improve the ability of our offices to address problems of loan guaranty fraud and to improve our success in obtaining prosecutions. For example, we have undertaken a joint VA/HUD audit and investigation in Puerto Rico where both we and the HUD Inspector General had indications of serious problems.

TARGET

The seventh challenge was to continue close monitoring of target implementation, with particular attention to protection against fraud, error and unauthorized disclosure. Target is an on-line computer system, estimated to cost $81.5 million, which on a phased basis is being installed to replace existing VA compensation, pension and education automated systems.

During the past year we completed four audits, which specifically addressed the adequacy of controls against unauthorized access and disclosure in violation of beneficiaries' rights to privacy. We believe at this stage of system implementation, appropriate and adequate steps have been taken to protect these rights.

We also completed two audits which addressed the adequacy of risk analysis studies performed by program, ADP and contractor staffs. The purpose of these risk analysis studies is to determine the vulnerability of systems and hardware to a broad range of risks such as natural disaster, sabotage, fraud, misuse, etc., and to determine cost effective means to reduce these risks to a tolerable level.

In addition to addressing the foregoing challenges, we have carried out a large number of other audit, investigative and vulnerability assessment activities during the year. The scope and results of these activities are reported in my semi-annual reports which have been provided to the Committee. At the time of my confirmation hearing I discussed changes in the scope and objectives of our operations which had been made to that date. These semi-annual reports point out additional changes, two of which have been particularly beneficial.

First, we have been an active participant in inter-agency audits and investigations. Clearly, a major benefit of the Inspector General Act of 1978 and the implementation mechanisms established, particularly the executive group to combat fraud and waste in Government, has been the development of inter-agency efforts to address problems which cross agency lines. Aside from joint audit/investigative activities, much has been done to identify and establish capabilities to meet mutual problems of recruiting and training staffs, developing common audit/investigative procedures, and the like.

Second, some of our audits, investigations and vulnerability assessments have reached into other Federal agencies and the private sector to ascertain how others have solved problems which VA may be experiencing. I believe that this has produced more practical recommendations reflected in many of our reports, including those dealing with heart pacemakers, timekeeping for part-time physicians, and ADP contracting procedures.

I would like to emphasize that the progress in addressing these seven challenges, as well as the total scope of our activities, could not have been obtained without the support of this and other committees of the Congress, the Administrator and many managers at all levels in the Veterans' Administration, and my staff of auditors, investigators and analysts.

To elaborate on my staff capability, I currently have 298 auditors, investigators, analysts and other professionals, 10 administrative personnel and 45 secretarial/clerical staff. The directors of my headquarters and field offices have many years of auditing or investigating experience in the Veterans' Administration. For audit supervisors and seniors in charge of major audits, 46 percent have 30 months or more of VA audit experience. Most of those who do not have this much VA experience do have significant audit experience with other Federal agencies. The primary exception would be those management analysts in our audit and risk analysis staffs whose prior experience was at VA medical centers, regional offices and other VA facilities.

The more complex investigations are usually handled by our senior investigators who have an average of 18 years of investigative experience and 50 percent of whom have been with us 30 months or more. Although most of the remaining investigators have been with us less than 30 months, they average 8 years of investigative experience.

I have also attached information at the suggestion of the Committee staff, comparing our resource capabilities and needs. The greatest need is restoration of the capability to perform more frequent audits of VA facilities. As indicated in my May 5 report to the Committee, a combination of losses in personnel strength and workload growth has caused us to reduce the frequency of audit cycles to 5 years. This seems to me to be the outside limit if we are to retain credibility. However, the slippage to a 5 year cycle greatly lessens the deterrent value which more frequent audits provide by encouraging quality management and compliance with operating and financial controls. The cycle slippage also lessens the likelihood of timely identification and correction of out-of-line situations.

The additional staff needs of this office are numerically significant. However, the additional costs of these needed resources are small when compared to the entities and programs being reviewed. For example, the average VA medical center represents a $30 million per annum operation. We will spend only about $35,000 to $40,000 once every 5 years to audit an entity which is accountable during that period for $150 million in operations and service to thousands of veterans.

As you know, my office has received increases in audit and investigative staff during the past several years. However, we started from a very low base. In fact, a few years ago a GAO report concluded that VA had the least audit capability, in relation to agency resources, of any of the 49 Federal audit agencies studied. Notwithstanding our staff increases since then, we remain at or near the bottom among the Inspector General offices in percent of resources applied to IG operations

when compared to total agency operations. I have included a copy of the latest data I have showing this.

Mr. chairman, I would like to comment on only one other matter as a part of this statement. There have been certain allegations and criticisms made against me personally and members of my staff. Some of these were valid and we promptly took corrective action. Others are legitimate expressions of those with differing points of view. We recognize, however, that there are persistent concerns in the medical community over the operation of my office. There are two kinds of criticisms that I would like to address in particular.

One kind is based on erroneous perceptions of accepted and authorized procedures for the conduct of audits and investigations. Were I to accede to the procedures suggested by such critics, I would be abdicating certain of the responsibilities entrusted to me and seriously weaken our ability to carry out the intent of the Inspector General Act of 1978.

Another group of allegations is lacking in factual basis but is accepted as valid and repeated by third parties who have no first hand knowlege of the true facts. The efficiency and effectiveness of our operation has been impacted by these allegations and criticisms.

I have had little opportunity to present the facts in response to these allegations to the medical community, in particular, at conventions, staff meetings, and other forums where such allegations and criticisms are discussed.

I am, therefore, very hopeful that this hearing will provide the opportunity to explore some of the allegations and complaints, to dispel those which are inaccurate, and to identify corrective actions which have been or should be taken to resolve legitimate problems in my operations.

I recognize, of course, that my operations are not perfect and that errors do occur. It has been my policy that all serious allegations of irregular conduct by auditors and investigators are to be promptly investigated by senior people on my staff. In addition, we are constantly aware of our need to supervise and train our staff in the proper conduct of audits and investigations.

Mr. Chairman, that concludes my prepared statement. I will be pleased, of course, to answer questions from the committee.

OFFICE OF INSPECTOR GENERAL TOTAL EMPLOYMENT, JUNE 1, 1980

	Headquarters	Field	Total
Professional:			
Immediate office	2		2
Audit	51	191	242
Investigation	12	36	48
Risk analysis	6		6
Total	71	227	298
Administrative:			
Immediate office	1		1
Audit	2	4	6
Investigation	2		2
Risk analysis	1		1
Total	6	4	10
Secretarial/clerical:			
Immediate office	2		2
Audit	9	18	27
Investigation	7	8	15
Risk analysis	1		1
Total	19	26	45

OFFICE OF INSPECTOR GENERAL, EXPERIENCE OF AUDIT AND INVESTIGATIVE STAFF

	Number of employees	Number employed in VA audit or investigative activities prior to January 1978	Average years of professional audit or investigative experience with VA or other agencies
Audit:			
SES	1	1	17
15	9	9	10
14	19	6	11
13	61	31	6
12 and below	152	16	3
Total	242	63	
Investigation:			
SES	1	1	29
15	2	2	24
14	5	5	23
13	10	5	18
12 and below	30	2	8
Total	48	15	

OFFICE OF INSPECTOR GENERAL, MINORITY AND FEMALE EMPLOYMENT BY GRADE LEVEL, PROFESSIONAL AND ADMINISTRATIVE STAFF

	Number of total staff who are minority and female					Percent of total staff
	SES	GS–15	GS–14	GS–13	GS–12 and below	Total
Immediate office				1		1	33
Audit		4	6	11	59	80	32
Investigation			2	3	9	14	28
Risk anaysis				2	1	3	43
Percent of total in each grade		33	23	35	32		

RESOURCE REQUIREMENTS

	Authorized staff	Staff needed	Difference
Immediate office	7	7	
Audit	274	422	[1] 148
Investigation	70	116	[2] 46
Risk analysis	7	13	[3] 6
Total	358	558	190

[1] Increased resources are needed for audit to maintain a reasonably frequent cycle of audits of all of VA programs, activities and functions and at the same time provide a substantial level of effort for (i) the review of ADP systems, construction projects and other large and often risky projects during the developmental phases of such projects, and (ii) conducting special audits to develop the extent of and a solution to fraud, waste and mismanagement in the programs and activities of the VA.

[2] Investigative activities consist of proactive and reactive investigations, document and personnel security programs and operation of a technical laboratory. Within 6 months after approval of the Inspector General Act, reactive investigation workload doubled and an upward trend has continued to date. Proactive investigative capability is generally perceived as an initiative stemming from the Act to aggressively search for fraud, rather than a total dependence of reacting to whistleblowers and other sources. The increased resources would enlarge this proactive investigative capability by 14 positions from 7 to 21, and increasing the number of proactive investigations per annum from 25 to 75. Reactive investigative capability would be increased by 32 positions, and the number of reactive investigations conducted per annum would slightly more than double from 120 to about 250.

[3] Risk analysis activities consist of assessing the vulnerability of programs, functions activities to fraud and waste, reviews of proposed legislation and regulations for such vulnerabilities, and operation of the employee hotline. Added staff will provide for doubling the number of vulnerability assessment, from 12 to 24 per annum, and increasing the depth of review of proposed legislation and regulations. It should be noted that the activities of the risk analysis staff all postdated and were established as a result of the Inspector General Act of 1978. No added resources were provided, but rather the staffing was obtained by internal realignment of resource.

The staff needs broken down between current capability and needs are:

	Current capability	Needs	Difference
Cyclical audits	197	295	[1] 98
Preinstallation reviews of ADP, construction and other projects	16	22	6
Special initiatives on fraud, waste and mismanagement	61	105	44
Total	274	422	148

[1] This provides for a 3-year cycle of all entities. If only medical centers and regional offices are addressed on a 3-year cycle, with all other entities, programs and activities on a 5-year cycle, the minimal need or difference is 40 positions.

INSPECTOR GENERAL RESOURCES RELATED TO TOTAL AGENCY BUDGETS

[Dollars in millions]

Agency	Fiscal year 1980 budget		Inspector General budget		Inspector General as percent of total	
	Positions	Amount	Positions	Amount	Positions	Amount
Agriculture	82,700	$20,543.7	897	$34.2	1.0	0.1
Commerce	29,600	3,216.8	116	5.3	0.3	.1
HUD	16,200	33,295.5	488	15.9	3.0	.04
Interior	54,400	4,438.5	159	7.0	.2	.1
Labor	22,300	27,534.5	392	25.4	1.7	.09
DOT	71,800	17,813.0	461	17.4	.6	.1
CSA	1,014	556.7	56	1.9	5.5	.3
EPA	10,900	5,086.8	123	9.2	1.1	.1
GSA	34,400	308.2	383	12.4	1.1	4.0
NASA	22,600	4,723.0	84	3.2	.3	.07
SBA	4,600	796.3	137	4.5	2.9	.6
VA	197,900	20,991.8	330	10.8	.1	.05
Subtotal	584,414	139,304.8	3,626	147.2	.7	.1
HEW	143,900	205,170.3	1,244	44.1	.8	.02
Energy	19,000	7,447.5	256	8.9	1.3	.12
Total	711,314	351,922.6	5,126	200.2	.7	.06

Note.—Congressional action increased the actual resources of the VA Inspector Generals office for fiscal year 1980 to 358 positions and $11.5 million.

Response of Allan L. Reynolds, Inspector General, Veterans' Administration to Written Questions Submitted by Hon. Alan Cranston, Chairman of the Senate Committee on Veterans' Affairs

Question 1. The Senate Governmental Affairs Committee report (S. Rept. No. 95-1071) accompanying H.R. 8588, which was ultimately enacted as the IG Act, states, "Broad as it is, the Inspector . . . General's mandate is not unlimited. Issues requiring substantive or technical expertise will often fall outside his proper sphere."

Question 1A. Do you believe that this legislative history indicates that the IG must refer issues requiring substantive or technical expertise to other offices for investigation or that the IG may refer such issues elsewhere—in other words, is a decision to refer such issues mandatory or discretionary?

Question 1B. (If discretionary) Is it your view that this discretion is vested in you—and not in any other VA official?

Answers 1A and 1B. I believe that the legislative history of the Inspector General Act clearly provides that the Inspector General's decision to refer or retain matters requiring substantive or technical expertise is discretionary and not mandatory. This discretion, of course, is subject to the limitation that the matters are within the mission responsibilities and duties of the Inspector General as set forth under sections 2 and 4 of the Act, or assigned by the Administrator under section 9(a)(2) of the Act.

Support for the position that this decision is within my discretion can be found in sections 6(a)(6)(7) and (8) of the Act. The first of these subsections authorizes the Inspector General to select, appoint and employ such officers and employees as may be necessary for carrying out the functions, powers, and duties assigned to the Inspector General's office. The second subsection (6)(a)(7) authorized the Inspector General to obtain services as authorized by 5 USC 3109 which deals with the hiring

of experts and consultants, and the last of these subsections (6)(a)(8) authorizes the contracting out for such services as may be needed.

Taken together, these 3 subsections provide the Inspector General with a variety of means to secure the technical or substantive expertise necessary to perform his mission responsibilities. They give the Inspector General "substantial autonomy in carrying out his operations . . ." (S. Rept. No. 95–1071, 95th Congress, 2nd session, p. 35)—This autonomy could only exist if the decision to refer or retain matters requiring substantive or technical expertise remains within the discretion of the Inspector General.

Legislative history further provides that "The committee is aware that in most cases the authority to select and appoint officers and employees, obtain services from consultants and enter into outside contracts rests with the agency head and is delegated as appropriate to subordinate officials. However, because of the unique function of the Inspector and Auditor General and the possibility that such authority might be denied to him, in order to hamper his operations, the committee has given him explicit authority to carry out these functions." Ibid.

One can only conclude that the explicit authority given to the Inspector General to carry out his function requires that he alone within the agency retains the discretionary authority to determine which matters to refer or retain.

The statement quoted in your question is followed by a specific example which suggests a distinction between program manager responsibilities and Inspector General responsibilities. To clarify our understanding of the intent, we are providing our own example of the distinction we draw from reviewing the legislative history, as follows:

Example 1: Assume that there are allegations brought to our attention that at a number of hospitals, surgery was being performed on ineligible patients by VA surgeons for an illegal fee, who then concealed the operations by falsifying operating room logs. This is a clear instance of fraud and abuse. Although technical and substantive expertise is required on matters such as operating room procedures, we would make the decision to investigate these allegations since they are clearly within the mission responsibility of the Office of Inspector General. It should be noted that there is also a quality of care implication which DM&S must consider, that is, there would be less resources available to perform surgery on eligible VA patients.

Example 2: Assume there were increased incidents of mortality in cardiac surgery patients due to lack of competent senior surgeons which were brought to our attention. Since this issue involves major quality of care implications but not fraud, we would not investigate this matter, but would refer it to DM&S.

In both examples, the allegations were brought to the attention of the Office of Inspector General and require substantive and technical expertise, and contain quality of care implications. We would only investigate the former, however, since the latter does not involve fraud, waste and abuse. Under the Medical Inspector proposal, we would pay close attention to the investigation of this latter situation through preconsultation with the Medical Inspector on the scope and resources to be used for this investigation, and we would review the investigative report for adequacy and appropriateness of recommendations.

Question 2. Your current Semi-Annual Report indicates that there are 3 basic problems with existing timekeeping procedures for part-time VA physicians: First, the procedures are unrealistic in light of the need for part-time physicians to deviate from scheduled tours of duty; second, they are unrealistic because timekeepers often do not know of changes from scheduled tours; and, third, they are vulnerable to fraud and abuse. The report indicates that new procedures making the prescheduled tours of duty more flexible have not alleviated the timekeeping accountability problems and have been criticized because physicians found the daily sign-in/sign-cut requirements unacceptable as being unprofessional. The report also indicates that your office has proposed a modification to these procedures which has been submitted to GAO for review.

Question 2A(1). Have you received comments from GAO on your proposed modification to current timekeeping procedures?

Answer 2A(1). Yes.

Question 2A(2). (If yes) Please summarize the GAO comments.

Answer 2A(2). GAO found the proposed procedures acceptable and in accordance with their policy and procedures manual. Their approval is based on the presumption that after being authorized in writing by the Administrator, the Controller will grant authority in writing to these employees to record their own time and attendance.

Question 2B. When will the modified procedures be finalized?

Answer 2B. We understand that the new forms are at the printers now. Also, the applicable procedures are in final concurrence process. DM&S hopes to implement these procedures by September 15, 1980.

Question 2C. Please provide a copy of the modified procedures as soon as you make a final recommendation and provide the DM&S comments on them.

Answer 2C. We will provide you a copy of the new procedures upon receipt.

Question 3. During the course of your office's April 13-August 16, 1979, investigation at the Denver VA Medical Center, the investigator's wife apparently received a threating telephone call at home. There was some dispute between the investigator and the physician under investigation as to whether the investigator had accused the physician of making the call.

Question 3A. In light of this situation, don't you think that the objectivity of the investigation was called into question?

Answer 3A. The objectivity of the investigation was called into question and was evaluated by the supervisory investigator who visited Denver in July 1979.

Question 3B. Why wasn't the investigator removed from the investigation?

Answer 3B. The investigator was not removed from the investigation because, based upon the supervisory investigator's evaluation, it was not believed that the objectivity of the investigation was compromised, and the majority of the investigative work had already been completed.

Question 4A. What are your office's policies and procedures with respect to various procedures for compelling the production of documents and testimony, such as the subpena power and search and seizure?

Answer 4A. It should be first noted that compulsory processes such as subpenas or search warrants are not required to obtain information from VA employees. Under VA regulations, VA employees have a duty to cooperate or be faced with possible disciplinary action.

Similarly, these compulsory processes should not be required to obtain records which relate to VA programs and operations whether sought from VA employees or others. Under section 6 of the IG Act, the IG is authorized access to these records.

TITLE 38 SUBPENAS

There has been long-standing authority under 38 U.S.C. 3311 for the Administrator or his designee to issue subpenas to obtain documents or testimony from non-VA employees. This authority is independent of and precedes by several years the authority to issue the IG subpena.

Our office policies and procedures are set forth in the Office of Investigations' Policy and Procedure Guide for Special Investigators which provides:

"The investigator should thoroughly review the matter to be investigated prior to departure from Central Office to anticipate possible subpena needs for discussion with the Assistant Director for Investigation at that time. The investigator should make every effort to obtain evidence without the use of a subpena and subpenas will be used only with the prior approval of the Assistant Director for Investigation. For preparation of a subpena in the field the investigator should contact the Manager of the Regional Office in the area in which the subpena will be served, explaining the need for it and request that it be countersigned by the Manager. If the Manager declines to countersign the subpena, or if for any reason it is considered inappropriate to obtain the subpena through the field station, the investigator should contact the Assistant Director for Investigation. Advice or assistance in preparation of subpenas may be obtained from the General Counsel or the local Chief Attorney.

"The subpena may be served by the investigator and a carbon copy will be filed in the investigation report exhibits bearing a notation by the investigator as to the date, time, place, manner of service, and the name of the individual served.

"The attendance of subpenaed witnesses cannot be compelled beyond a radius of 100 miles and they are entitled to fees and mileage which will be paid by the office issuing the subpena. The investigator will report failure to respond to a subpena to the local Chief Attorney and request him to invoke the aid of the U.S. District Court to secure compliance with the subpena, as provided in 38 U.S.C. 3313."

IG SUBPENAS

The Inspectors General have been working with the Department of Justice to develop policies and procedures with regard to these subpenas. We are not in the process of developing policies and procedures to cover our subpena authority under the IG Act. We have been working closely with General Counsel, other IG offices, and the Department of Justice in the development of these policies and procedures.

SEARCHES

We are presently reviewing rule 41, Federal Rules of Criminal Procedure, to determine whether investigators of our office are civil officers of the United States who are authorized to enforce or assist in enforcing any law thereof. There are other procedures, however, which cover the search of areas of VA employees and others.

Our policy regarding searches and seizures as set forth in our policy and procedure guide is quoted as follows:

"The search of desks, lockers, quarters and automobiles raises questions of 4th Amendment prohibitions against unreasonable search and seizure. They are the subject of General Counsel Opinions of January 24, 1958; April 26, 1963; and December 10, 1963. Generally a search warrant is required in the absence of consent of the individual occupying or assigned to a desk, locker or quarters. However, these may be searched without permission if there is reason to believe they contain Government property which is needed for use. Search of an automobile without a warrant is permissible if there is probable cause to believe the specific automobile is involved in the apparent consummation of a criminal act.

"Consent of an individual to search his desk, locker, automobile or quarters (on or off the station) must be in writing signed by him and witnessed and must clearly show that it is given voluntarily and that he understands and waives his constitutional protections against unreasonable search and seizure. A witness should be present at a search and a record made and witnessed of the contents of the area searched and any material removed."

These policies and procedures are also under revision and will also be incorporated into a new policy and procedure guide.

Question 4B. What are your office's policies and procedures regarding arrests?

Answer 4B. Our investigators are not authorized to make arrests. In the event an arrest is indicated in a case under investigation by our office, the matter would be coordinated with appropriate arresting authorities.

Question 4C. What training are your staff members given in the use of subpenas, search and seizure, warrants, and arrests?

Answer 4C. All of our investigators have or will be required to attend the White Collar Crime Seminar given at the Federal Law Enforcement Training Center, Glynco, Ga., where training is furnished in these areas.

Most of our investigators have extensive investigative backgrounds (average 11 years prior to entering our office) and have had training in these areas from Federal, state and local law enforcement agencies.

We are also developing an in-house training program where additional training in these and other areas will be furnished. Each of our investigators will attend an appropriate 2-day training session in the fall of this year.

Question 5. Do you believe that in light of your responsibilities, you have sufficient power to search for and seize evidence and make arrests under the Inspector General Act?

Answer 5. The power to search for and seize evidence is a matter that has been the subject of a coordinated review by all of the Inspectors General. Our position in these discussions is that we do not believe in light of our responsibilities, that we have sufficient power to search and seize evidence. Because of possible destruction or alteration of documents and other evidence by subjects of a criminal investigation and their accomplices, we can foresee a definite need for extension of the authority to execute a search warrant to investigators of this Office. We note that it has been recently necessary to issue a search warrant in one of our cases. This could only be accomplished through a linkup with another agency which has the authority to execute search warrants. We can foresee instances where this linkup will not and may not be practical.

Likewise, although the circumstances would most likely be very limited, we can foresee a need to have the power to make arrests in carrying out our responsibilities. If such powers are obtained, they would only be used by investigators trained in the use of these authorities, subject to high-level approval and with the knowledge of United States Attorneys' offices.

Question 6A. How many subpenas did your investigators issue last year?

Answer 6A. None.

Question 6B. Please describe the circumstances under which the subpenas were issued?

Answer 6B. In those circumstances in which it would have been appropriate to issue subpenas pursuant to the Inspector General Act, we have been working closely with a United States Attorney's office. Accordingly, the information sought was more properly obtained by a grand jury subpena since the information related to criminal matters then under investigation.

Question 7A. Please describe the arrangements that exist between your office and the Department of Justice and U.S. attorneys relative to criminal investigations.

Answer 7A. The only formal arrangement consists of an agreement between the Attorney General and the Administrator of Veterans' Affairs dated April 22, 1954. Under this agreement, when any information is received by the VA which indicates violations of Federal criminal statutes in connection with certain specified acts involving VA programs (generally education or loan guaranty matters), this information is referred to the FBI. The agreement does not prevent the VA from conducting an administrative investigation on referred matters concurrently with the FBI.

Our office of investigations routinely reports all criminal matters investigated to either a U.S. Attorney's office or the Department of Justice for guidance, further investigation or referral for prosecutive action.

Question 7B. Are there any areas in which better cooperation or more effective working relationships are needed?

Answer 7B. Cooperation and working relationships have been satisfactory. However, we are presently exploring various concepts in an effort to further enhance our working relationships with the Department of Justice and U.S. Attorneys. We are also in the process of developing investigative priorities which will take into consideration the better development of prosecutable cases. In this regard, our field office directors and representatives of our Central Office staff will meet with U.S. Attorney offices to find what types of cases are more likely to be prosecuted and more likely to result in a conviction.

To enable us to work better with Federal prosecutors, we intend to intensify our training of investigators in areas that are particularly applicable to criminal fraud cases (that is, the elements of federal criminal offenses, grand jury procedures, rules of evidence, et cetera).

New methods of presenting our cases to U.S. Attorneys are being developed to enhance the likelihood of prosecutions and steps will be taken to develop a new agreement with the Department of Justice which will better reflect present prosecutive standards.

Question 8. Do your investigators use the Handbook for Investigators prepared by the Division of Inspection, Training, and Review of the Department of Health and Human Services, or any similar handbook?

Answer 8. Our investigators do not use the Department of Health and Human Services' handbook. Our investigators are issued a Policy and Procedure Guide which was prepared by our Office of Investigations. This guide sets forth our investigative policies and the procedures to be followed by our investigators. This guide is presently being revised to make it more responsive to our expanded responsibilities and to incorporate recent legal decisions.

Question 9. With respect to education overpayments, you indicated in your May 5 report that mail-intercept procedures and speeding-up the processing of and actions on notices of change in status of educational benefits recipients should significantly reduce overpayments.

Question 9A. What guidelines for timeliness are you recommending?

Answer 9A. Our draft report on the "Educational Accounts Receivable Audit" has just been transmitted to the Department of Veterans Benefits for comments. Although it is the department's responsibility to determine specific standards on timeliness, the report suggests the following guidelines: Defining immediate processing for terminations as two working days during the critical period of the cycle; and, including notices of reduction in training in the working definition of cases requiring immediate processing during the critical period.

Our formal recommendation on mail-intercept procedures and speeding-up the processing on changes are:

(1) That the Chief Benefits Director provide adjudication personnel with specific criteria for timely action on notices of termination and reduction.

(2) That instructions for check interception state the conditions under which interception will be involved, and the success rate of check interception be reviewed to evaluate effectiveness.

Question 9B. By what amount and by what percentage do you expect that overpayments can be reduced in fiscal year 1981 as a result of these actions?

Answer 9B. Originally, as reported in our semi-annual report issued March 31, 1979, we projected a $49 million reduction in overpayment. Our tests indicated that the situation where mail-intercept procedures may be possible occurred in about 18.7 percent of the overpayments. We also projected that mail intercept procedures may be effective in about 75 percent of these situations. The value of educational accounts receivable established in fiscal year 1979 was $350,334,000. When this figure is projected by 75 percent of 18.7 percent (14.03 percent) it equals about $49

million. This information was presented to the Chief Benefits Director and Controller in July 1979.

Since then the Department of Veterans Benefits and Controller have taken action to formulate revised check interception procedures. The Department of Veterans Benefits issued revised procedures in November 1979. Our limited sample had shown that check interception was about 60 to 75 percent successful but this was based upon less than comprehensive application. The VA Center Philadelphia has completed a systematic analysis of check interception and found a 50 percent success rate. If this 50 percent success rate holds steady, and our previously estimated rate of check interception applying to 18.7 percent of the receivable amounts established doesn't alter, we can expect a 9.35 percent reduction in fiscal year 1981 overpayments at an estimated amount of $32.8 million.

Due to the variety of factors which affect overpayments, we cannot furnish a more precise estimate of these savings or the projected savings on improving timeliness of processing.

Question 10. Your May 5 report also stated that a draft audit report to the Department of Veterans' Benefits noted that 58 percent of educational assistance overpayments are attributable to delays by veteran beneficiaries and educational institutions in reporting terminations or reduced training time. However, you note that you have not yet identified a practical solution to this problem and will be discussing the matter further with DVB. Please provide the Committee with a copy of the audit report as soon as it is finalized.

Answer 10. A copy of the audit report will be forwarded as soon as it is finalized.

Question 11. You also recommend improvements in the compliance surveys conducted by VA regional offices as a means of improving the timeliness of reporting changes in status by educational institutions and indicated that DVB had published a comprehensive training guide for compliance survey specialists in February 1979.

Question 11A(1). Did you review the training guide before it was issued?

Question 11A(2). Do you believe that the guide will help reduce overpayments significantly?

Answer 11A(1). No.

(2). Yes. The guide is comprehensive and well done.

As the quality and effectiveness of surveys increase we should see an increase in the detection of overpayments. The surveys should identify schools guilty of negligence in reporting changes of status and terminations. In the long run as schools are prosecuted under school liability provisions of the law there should be a substantial reduction in overpayments.

Question 11B. Are compliance surveys being strengthened in terms of staffing, or is the survey program being reduced for budgetary reasons?

Answer 11B. We have not found that the survey program is being reduced for budgetary reasons. The staffing problems were caused by temporary shifts of education benefit specialists to other functions, such as veterans assistance, in order to meet unusually high workloads. We believe DVB continues to recognize the importance of the compliance survey program. About 11,800 surveys were performed in fiscal year 1979. DVB estimates that 12,500 will be done in 1980 and 13,500 in 1981.

Question 11C. Do you have any other suggestions on how to improve the timeliness of educational institutions in reporting changes in status?

Answer 11C. We believe more can be done in the area of prevention by vigorous pursuit of collection of overpayments from schools when they are found to be negligent in reporting changes in status. Increased use of this remedy should encourage schools to place more emphasis on VA reporting requirements. This, along with more frequent compliance inspections and inter-agency sharing of information on problem schools, should improve the timeliness of educational institutions in reporting status changes. The cost effectiveness of such changes can only be determined after some trial period.

In our draft report "Educational Accounts Receivable Audit," we are recommending to the Chief Benefits Director that computer generated turnaround cards be included with each check sent to beneficiaries training at institutions of higher learning for use in reporting changes in status, when they occur. We believe that this recommendation if implemented would be an effective method of avoiding reporting delays.

We believe that it should be recognized that the nature of the program (reliance on beneficiaries and schools to report changes that reduce benefits) makes overpayments inevitable. We should continue to concentrate on solutions which affect areas in which our influence is effective or over which we have control. These include education of beneficiaries and schools of VA requirements, faster processing of status changes by VA regional offices, check intercept procedures, more frequent

and better quality school inspections, and vigorous pursuit of collection from veterans and negligent schools.

Question 12A. To what extent are VA work-study students currently being used at educational institutions to identify promptly veterans who have dropped out of courses and to report overpayments?

Question 12B. What potential role could work-students play in these respects?

Answers 12A and 12B. We have not completed any reviews of this subject. We are informed by the Department of Veterans Benefits that there is no system in place to track the extent to which work-study personnel are used at educational institutions to identify dropouts and report overpayments. The VA does not specifically require work-study personnel to be used for this purpose.

We are advised that the VA is in the process of revising procedures to provide that, where there are recurring overpayment problems at an institution, the work-study coordinator at the regional office will explore with the school administration the use of work-study personnel to help alleviate the problems.

The Office of Audit will monitor the actions taken, particularly to attempt to assure that revised regulations are released on a timely basis, and that educational institutions are contacted.

Question 13. Your May 5 report also indicated that audits at 16 regional offices showed that at 6 of them systematic analysis of error trends of adjudication benefit claims was not being properly performed in adjudication divisions and that 5 audits identified problems with the quality of administrative decisions which affected overpayments.

Question 13A. To what extent did those administrative decisions actually result in overpayments?

Answer 13A. The administrative decisions did not result in overpayments. The decisions we are referring to in the May 5 report are decisions to write-off overpayments because they were caused by VA error, rather than establishing a receivable and pursuing collection from veterans. We found that the decision process did not follow prescribed procedures for documentation, justification and approval of write-offs. Our limited samples of administrative error write-offs found only about $5,000 of overpayments improperly written off. At one regional office we found that all awards correcting administrative errors were not being submitted for review and we, therefore, could not determine the full extent of administrative error write-off.

Question 13B. What recommendations did your office make to correct them, and have those recommendations been implemented by the regional offices?

Answer 13B. We recommended correction of improper write-offs and review and analysis of error decisions to identify training needs and to assure compliance with VA procedures and criteria for write-offs. All regional office directors concurred with our recommendations and have reported implementation.

We feel that these findings may be indicative of a larger problem and are presently working on a proposal to conduct more in-depth audits in this area.

Question 14. A draft audit report on the Centralized Accounts Receivable System—"CARS"—recommends that collection action be pursued through Government channels when the debtor is an employee of the Federal Government. I understand that your office is working out arrangements for a governmentwide computer matching between VA accounts receivable records and Federal Government personnel records to identify Federal employees who are indebted to the VA.

Question 14A. What action can be taken against a Federal employee who refuses to pay an indebtedness to the VA?

Answer 14A. The GAO report on, "Unresolved Issues Impede Federal Debt Collection Efforts—A Status Report" states that:

"* * * under present legislation, the current salary of a Federal employee may not be withheld to satisfy general debts owed to the Government. At present, a Federal employee's salary may only be withheld to satisfy erroneous payments made by an agency to its own employees or travel or transportation advances paid to employees since there is specific statutory authority for the collection of these debts against current salary. (See 5 U.S.C., sections 5514, 5705, and 5724(f).) Any other offsets are contingent on obtaining employee consent.

"The alternatives to collecting general debts from the current salary of Federal employees include legal action, collection from pay entitlements upon separation from Federal employment, collection from civil service annuities, or disciplinary action (which is rarely exercised) under Executive Order 11222, 30 F.R. 6469. These alternatives have proven to be largely ineffective, costly, and/or time-consuming.

"Under the current system, many debts are referred to the Office of Personnel Management for offset from annuities, lump-sum withdrawl of employee retirement contributions, or payments for salary or lump sum leave. Several recent Federal court cases have dramatized the problems which arise in collecting debts from

retired Federal employees. By the time the Government begins to collect the debt by offset, the claim is often stale, the facts are forgotten, court action is barred, and collection may impose a significant financial hardship on the annuitant. In addition, the debt may be greatly increased by interest charges. As a result, the courts seem to be favorably inclined towards lack of due process arguments which have been raised by annuitants faced with offset actions."

Aggressive collection efforts involving Federal employees are further hampered by requirements for disclosure of identifying information and other data to a Federal employer. Our General Counsel advises that:

"A disclosure of claimant records must be consistent with 38 U.S.C. § 3301(b)(3) and the implementing VA Regulation 506. The Statute specifies that the VA should disclose a claimant's name when 'required by any department or other agency of the U.S. Government'." VAR 506 defines this statute by explaining that the disclosure of claimant records may be made to a Federal agency upon 'an official request, written or oral, from such department or agency.' In the request, the Federal agency must state the official purpose for requiring the record(s). In the instant case, with regard to the disclosure of claimant records to a Federal employing agency following the initial contact with the claimant, the VA should obtain a written or oral request from the employing agency."

Question 14B. By how much do you expect collections to be increased in fiscal year 1981 as a result of this effort regarding Federal employees indebted to the VA?

Answer 14B. VA believes that potential recoveries from this match, based upon past collection experience, will range from $1.2 million to $15 million. This is based upon an estimate that we will identify between 10,000 and 12,000 indebted veterans who are also Federal employees.

Question 15. The "CARS" audit identified over 13,000 accounts receivable amounting to over $1.7 million which were due from service persons on which collection action had not been pursued through the Department of Defense. What action is being taken to collect these overpayments?

Answer 15. The "CARS" audit report recommended that collection action be pursued with the appropriate military organization on all terminated accounts receivable that can be identified as a serviceperson's account. Comments on the report recommendation have not been received from all the departments and staff offices involved. The Controller has indicated reluctance to attempt to collect these overpayments because he doesn't feel that it would be cost beneficial under the present legislation.

Question 16. An IG draft audit report indicates that Regional Office staffs failed to identify 36 percent of the instances where there is potential liability on the part of the educational institutions.

Question 16A. What recommendations have you made to correct this situation?

Answer 16A. Our draft report "Education Account Receivables Audit" will be released to the Departments and Staff offices for comments on the findings and recommendations shortly. A claims folder review of 536 cases identified 295 cases (36 percent) where potential liability existed, but appropriate action was not taken. This deficiency was not identified by the stations systematic quality control reviews. As a result of these findings, we are making the following recommendations to the Chief Benefits Director:

1. That controls be established to insure that Systematic Quality Control reviews evaluate the identification and reporting of school reporting error as a discrete element of the review.

2. That the Adjudication Officer provide the Veterans Services Officer with a monthly report of school reporting errors identified, to assist in scheduling compliance surveys.

Question 16B. Have these recommendations been implemented by DVB?

Answer 16B. While the Department of Veterans Benefits has not had an opportunity to review the findings and recommendations contained in this report, the Chief Benefits Director (CBD) in VA letter 20–80–5 dated February 28, 1980 instructed all station Directors to review their school liability activity to ensure that it conforms to existing directives. The CBD directed that special attention be given to ensuring that Notices of School Reporting Error forms are properly prepared and reviewed. I believe that acceptance and implementation of our recommendations will further strengthen this school liability activity.

Question 16C. What action has been taken to recover these overpayments from the educational institutions?

Answer 16C. In August 1975 the agency was given the authority to collect from educational institutions the amount of an overpayment made to an eligible person or veteran as a result of the willful or negligent failure to report excessive absences.

discontinuance or interruptions of a course, or as a result of false certification. The Department of Veterans Benefits (DVB) issued a series of implementing circulars.

In April 1977, a moratorium was established on the assessment of school liability, pending resolution of court imposed injunctions which resulted from lawsuits brought by certain schools. The moratorium was lifted in March 1979 after the VA had succeeded in winning decisions which affirmed the agency's right to make such assessments. The Department issued DVB Circular 22-79-6, dated March 6, 1979, which lifted the moratorium, and revised and consolidated procedures for handling school liability cases. The most significant changes in procedure contained in the new circular related to due process in assessing school liability. The program of assessing school liability appears to be gaining momentum. As of March 31, 1980, $109,310 had been recovered from 23 schools. The June 30, 1980 report shows $178,557 recovered from 25 schools.

While these amounts seem small in view of the agency's total education accounts receivable balance, $405 million as of March 31, 1980, I believe that aggressive implementation of the provisions of title 38, U.S.C., section 1785 will result in:

(1) Collection of monies due the agency which would otherwise not be collected and,

(2) Substantial improvement in the quality and timeliness of school reporting. While not easily measured the latter has potential for preventing or limiting future overpayments.

Question 17. In your May 5 report you indicate that a potential means of increasing pension beneficiary awareness of the income and expenses reporting requirements is through extensive use of the media.

Question 17A. What specific recommendations did you make in this regard?

Answer 17A. In September 1979, we met with the Chief Benefits Director to discuss the Pension Benefits Accuracy Study. As a result, it was agreed that a media effort would be undertaken to alert elderly beneficiaries of the unusual medical expense deductions. Subsequently, a press release was prepared and issued.

Question 17B. Has DVB indicated a willingness and ability to implement those recommendations?

Answer 17B. Since that time, we have met with program managers to explore other avenues of reaching the elderly population to heighten their awareness of unusual medical expenses and the need to report them. Currently, we are preparing specific recommendations on this issue, including a special alert through the check stuffer system.

Question 18. From time to time the Committee receives mail from persons complaining that certain individuals receiving VA pension have substantial income or real estate holdings.

Question 18A. Have you received similar correspondence or telephone complaints?

Answer 18A. Allegations concerning the abuse of veterans benefits have been received by the Office of Inspector General. These complaints have come primarily through referrals from GAO's hotline as well as our own. Most of the complaints do not specify whether the alleged abuse involves compensation or pension but generally claim the person is receiving unwarranted benefits.

Question 18B. What steps do you take in response to any such complaints?

Answer 18B. Incoming complaints are initially reviewed to attempt to determine the seriousness of the allegations. If the allegations appear to raise important questions about a program area, they are referred to the Office of Audit. If the charges imply fraud, or other criminal activity, they are referred to the Office of Investigations. In the case of alleged abuse of veterans benefits almost all cases are initially referred to the Department of Veterans Benefits (DVB). Since DVB has the capability of quickly determining the correct benefits, they can usually resolve the issue. In the first 1,000 hotline cases, some 87 have involved veterans benefits but only one case was referred to the IG's staff rather than DVB. This case was referred to the Office of Audit because the allegation implied program problems. The allegations were, upon review, determined to be unfounded.

Question 18C. How many cases resulted in an investigation during the past 6 months, and what were the results of those investigations?

Answer 18C. None of the cases involving veterans benefits were undertaken by our Office of Investigations. As previously mentioned, there have been 87 referrals involving compensation or pension allegations. The allegations have been substantiated in 13 cases. For example, in one compensation case, a field examination was conducted. DVB found that benefits had been awarded because of fraud. Benefits were discontinued and the case was sent to the U.S. Attorney for prosecution. Fifteen cases are still open and under review. The remaining 59 referrals were unfounded. Five of the 87 referrals specifically involved pension cases. Of these,

three were founded and collection procedures to retrieve the overpayments were begun.

As stated in our Semi-Annual Report No. 3, it appears that many people in the general public do not understand veterans benefits, particularly compensation. The tenor of the complaints received, indicates that most of those making the allegations believe the receipt of benefits precludes the veteran working.

Question 19. Recently, there have been press reports that some incarcerated individuals were feigning mental disability in order to qualify for Social Security benefits.

Question 19A. Have you received any complaints or conducted any investigations concerning VA compensation or pension benefits payable to incarcerated individuals?

Answer 19A. No.

Question 19B. If so, have you discovered any instances in which benefits were improperly claimed by and awarded to incarcerated persons?

Answer 19B. Not applicable.

Question 20. What efforts have you made during the past year to review the adequacy and validity of DVB quality control procedures in the compensation, pension, insurance, and burial benefits program?

Answer 20. During 16 cyclical audits of DVB regional offices conducted since April 1, 1979 the Office of Audit has reviewed various aspects of quality control over compensation, pension or burial benefits claims processing at 13 facilities. Because of resource limitations a complete review of all aspects of quality control at any one facility is not possible. The audit team based on research during the preparatory phase of an audit, selects the benefit program or programs that it will review and defines the scope of the audit. A typical audit might include topics such as, determining the quality of pension claims processing; an evaluation of the station's systematic quality control procedures; specific aspects of the office's systematic analysis of operations; and various divisions' analysis of error trends. As a result of our cyclical audits 19 recommendations directed specifically at improved quality of compensation, pension or burial benefits processing were made by audit teams and concurred in by regional office directors.

In addition to cyclical audits, we have conducted specific audits which address the processing quality of these programs. For example, our audit of the Manila regional office was specifically directed at insuring that only eligible beneficiaries were receiving benefits and assessing controls used to prevent program abuse. The "Audit of Insurance Program Management Division" reviewed and evaluated the adequacy of established policies and procedures. Another audit examined the accuracy of computer master records by comparing claims file information with master record data. We have also audited the compensation, pension and education master files to determine whether duplicate payments were being made. These audits will result in the establishment of approximately $3 million in overpayments.

We have also reviewed the adequacy of the Department's quality assurance program and compared it with that of the SSI program. We found three conceptual differences between these quantitative measurement systems: (i) the Department's quality control program does not account for dollar losses caused by adjudicative errors; (ii) the quality control process does not assess the entire case, but limits its review to certain transactions; and (iii) the Department's program does not utilize independent supervisory personnel to perform quality reviews. The Department has, however, integrated these features of the SSI program into the pension verification program. This should provide a future basis for judging whether adoption of the SSI quality control features or some other changes are appropriate.

Question 21. Do you consider that your present staffing level is sufficient to carry out adequate investigations and audits of the loan guaranty program?

Answer 21. We do not think that our current staffing level is large enough to do adequate audits of the loan guaranty program or, indeed, or any of the major VA programs. Our audit universe has at least 1,619 entities (offices, activities, programs, facilities, etc.) which we are responsible for auditing. There are at least 21 distinct audit entities within the Veterans' Housing Program. Ideally, each of these entities should be periodically audited, but we cannot do this with our current staffing. In addition, most VA regional offices have Loan Guaranty Divisions which should be audited during our regular cyclic audits. We are now auditing regional offices every 5 years. With regards to investigation, our staffing level is minimally sufficient for conducting strictly reactive investigations into complaints received regarding irregularities in the loan guaranty program. Our staffing level is not adequate, however, to conduct any type of extensive proactive investigative program, nor would it be adequate to conduct many additional reactive investigations should DVB develop indications of widespread fraud and abuse in this program.

Question 22. What accounts for the increase—from $125.2 million in March 1979, to $143.7 million in March 1980—in the amount of loan guaranty indebtedness?

Answer 22. The increase in accounts receivable is partially caused by the "snowball" effect. As long as annual establishments exceed dispositions, the balance will steadily increase. The following statistics on accounts receivable show that the percentage rate of increase is slowing.

LOAN GUARANTY ACCOUNTS RECEIVABLE

[Dollars in thousands]

Fiscal year	Accounts receivable balance—end of year	Percent increase over previous year
1971	$43,850	
1972	47,906	1.09
1973	53,663	1.12
1974	61,338	1.14
1975	67,676	1.10
1976	80,010	1.18
1977 [1]	101,136	1.26
1978	117,073	1.16
1979	135,026	1.15
1980 [2]	143,700	1.06

[1] Includes 5 quarters.
[2] One-half year only.

Specific reasons for increases for 1980 are shown in the following chart:

LOAN GUARANTY ACCOUNTS RECEIVABLE

[In thousands of dollars]

	October to March fiscal year 1979	April to September fiscal year 1979	October to March fiscal year 1980
Beginning balance	117,073	125,230	135,026
New receivables established	20,079	19,949	15,599
In transit items	(81)	572	191
Total receivables to be collected	137,071	145,751	150,816
Less dispositions:			
Cash collections and offsets	3,076	3,041	3,296
Waivers and compromises	2,922	2,905	2,397
Termination of collection actions	5,843	4,779	1,423
Total dispositions	11,841	10,725	7,116
Ending balance	125,230	135,026	143,700

A comparison of the activity from October through March 1979 to that of October through March 1980 shows that the dollar value of new receivables established decreased 22 percent and collections increased 7 percent. Two factors, waivers/compromises and termination of collection action, decreased during the period. Since these factors reduce the receivable balance their reduction effectively slowed the decrease in accounts receivable balance. Waivers and compromises decreased 18 percent and terminations decreased 75 percent. The reduction in terminations is due to a change in policy. Previously, when accounts were submitted to GAO for collection action, they were recorded as terminated in VA books. In the future, these accounts will be referred to the Department of Justice and will remain on our books until disposed.

An additional restriction of collecting loan guaranty accounts receivable is that legally (USC 38 § 3101(b)) the VA cannot offset debts by withholding compensation or pension payments without the debtors consent.

Question 23. Your audit of selected aspects of the loan guaranty program at regional offices indicated the need for improvements in the servicing of home loans in default, property management, and loan processing.

Question 23A. What reasons did the regional offices give for the reported failure to comply with Central Office directives for administering the loan-guaranty program?

Answer 23A. The most common reason given by regional office personnel for failure to comply with Central Office directives for administering the loan guaranty program was a lack of sufficient staffing. Other reasons given included: misinterpretation of a manual requirement, and difficulty in appraising certain properties due to their location or poor condition.

Question 23B. What recommendations did your office make to improve regional office performance?

Answer 23B. This report is still in the "draft" stage. Formal comments from the Department of Veterans Benefits have not been received. Our tentative recommendations to improve performance in the areas of defaulted loan servicing, property management, and loan processing include:

That DVB take action to ensure that mortgage holders give notice to the VA within 105 days after any debtor defaults.

That DVB timeliness standards for input of Notice of Default information into the LCS be clarified.

That DVB re-emphasize the need and responsibility for adequate, timely supplemental servicing.

That DVB take action to ensure that all regional offices review notices of default and initiate personal servicing when the holder's servicing has been inadequate.

That DVB take action to ensure that initial property analyses are conducted within VA timeliness guidelines at all regional offices.

That DVB take action to ensure that: (a) all regional offices provide accurate default appraisals; and, (b) non-upset bids are submitted when appropriate to minimize losses to the VA.

That the regional office review and adjust its criteria for determining that title examination charges are reasonable and customary.

That management ensure local guidelines are followed when considering the disposition of the veteran's application for a loan.

Question 23C. (1) Did the audits find any evidence of employee negligence, incompetence, or mismanagement?

(2) If so, what follow-up actions did you recommend and were your recommendations followed?

Answer 23C. We found no evidence of employee negligence, incompetence, or mismanagement.

Question 24. Under current law, the VA is required to conduct random on-site inspections of mobile homes purchased by veterans using their VA loan guaranty entitlement.

Question 24A. Have you audited VA's compliance with this inspection requirement?

Answer 24A. We have not audited VA's compliance with the law requiring on-site inspections of mobile homes purchased by veterans and the mobile home manufacturing process. However, this area is among those being proposed for your fiscal year 1981 audit plan. My staff is currently working on a proposal for auditing both aspects of VA's mobile home inspection requirements. This audit will be effectiveness oriented.

Question 24B. (If yes) What have been the results of your audits?

Answer 24B. If this proposal is included in our fiscal year 1981 audit plan, the results of the audit will be forwarded to the Committee upon completion of the final audit report.

Question 25. What efforts have you undertaken to assure that VA and VA-approved lenders are in full compliance with pertinent provisions of the Equal Credit Opportunity Act, Real Estate Settlement Procedures Disclosures Act, and fair housing laws?

Answer 25. We have never undertaken an audit effort specifically designed to assure that VA and VA-approved lenders are in full compliance with the pertinent provisions of the Equal Credit Opportunity Act, the Real Estate Settlement Procedures Disclosures Act, and the fair housing laws. However, these laws are reflected in VA manuals and regulations and coverage is provided during our audits of loan processing and servicing operations at regional offices.

Question 26. You indicated that action has been deferred on plans, based on information from the first quarterly report, to establish a pilot project at one or

more regional offices to accumulate information on "discrepant cases" involving brokers as well as cases involving lending institutions.

Question 26A. How many "discrepant cases" involving real estate brokers were reported in the first quarterly report?

Answer 26A. The information upon which the first quarterly report was based does not delineate between lending institutions and real estate brokers. We plan to work with DVB in developing a reporting system in which information involving brokers is reported separately from information involving lending institutions.

Question 26B. If future reports indicate more significant number of discrepant cases involving brokers, will plans for the pilot project be reinstituted?

Answer 26B. If future reports indicate more significant numbers of cases involving brokers, DVB will reevaluate the advisability of establishing a pilot project at one or more regional offices to accumulate information.

Question 27A. What audits or investigations have you undertaken concerning the VA vendee loan program—the program whereby the VA sells properties it has taken title to as a result of a VA home-loan default?

Answer 27A. Various loan guaranty subjects, including aspects of the VA vendee-loan program were examined in two audits completed in fiscal year 1979. These were the Audit of Property Management Operations of the Loan Guaranty Division, Jacksonville, Fla., and the Audit of Controls Over Property Management Brokers and Repair Contractors.

One investigation completed in 1979, uncovered irregularities in the vendee loan program. It involved a VA employee using inside information to acquire a portfolio loan property without going through the proper process.

Question 27B. In your view, is the turnover of properties in the vendee-loan program satisfactory?

Answer 27B. Based on the two audit reports, I believe turnover could be improved. Both reports pointed out the existence of delays which hindered prompt property turnover. For example, delays in obtaining District Counsel's rulings on acceptability of titles for VA-acquired properties hindered prompt resales and increased VA's holding costs. Other delays affecting property resales were attributed to staffing deficiencies and improper monitoring of brokers' and repair contractors' activities. The General Counsel and Chief Benefits Director agreed to take a number of actions which should satisfactorily address these problems.

Question 27C. Do the current vendee-loan procedures generally tend to favor sales to speculators?

Answer 27C. This aspect of property management has not been specifically addressed by us, but the policy of the VA is to attempt to sell acquired properties to individuals who plan to use them for their primary residence. In fact, there is a 15-day waiting period from the time a property is listed for sale before offers of "VA Affiliates" (a group consisting of brokers, their associates, contractors, VA employees and close family members) can be considered.

On occasion, however, it is advantageous to prepare groups of hard-to-sell properties and to solicit the interest of investors, builders, speculators, or others who purchase property for investment purposes. Field stations do have the authority to approve bulk sales after applying stringent criteria. Deviations must have been prior Central Office approved.

Question 28. At your confirmation hearing, it was suggested that consideration be given to working out an arrangement between the IG's office and the General Accounting Office for the GAO to do some targeted investigation in areas where you have found indications of fraud, abuse, or mismanagement, but which may be lower on your priority list than on theirs.

Question 28A. Have you given any thought to this suggestion and have any arrangements of this type been worked out with GAO?

Answer 28A. The resources GAO has available for audits of the Veterans' Administration are significantly less than those available in my office. Most of these GAO resources are committed to audits requested by the Congress. My recent discussions with Mr. George Peck, the resident GAO manager at VA, confirm that his office lacks the capability to take on our lower priority work and, in fact, he has looked to us to take on some of his lower priority work.

Question 28B. Have there been any instances of duplication of efforts by your office and by GAO?

Question 28C. How do you coordinate your efforts with GAO's?

Answers 28B and 28C. There has not been any instances where there has been substantial duplication of effort. In some cases, both we and GAO have undertaken reviews which have areas of overlap. However, there has been a free exchange of information which has reduced the duplication of efforts to a minimum.

It should be recognized that the potential for duplication is great as both we and GAO try to target our efforts on the most sensitive and serious problems. However, we and GAO exchange information regarding our respective audit plans and, as the need arises, we share information developed as our audits progress and by exchanging copies of audit reports.

In my personal experience in four agencies of the Federal Government, the working relationships of our office and GAO at the Veterans' Administration are distinctively superior to those I have previously experienced. These working relationships have served to minimize duplication.

Question 29. In section 1, pages 10 and 11, of the current Semi-Annual Report, you indicate that 34 medical center audit reports showed the need to make various improvements in the handling of medications—including controlled substances. You also indicated that a vulnerability assessment of medication handling, based on information available in fiscal year 1978, showed that the estimated dollar loss for drugs which may be stolen, dispensed without appropriate records, or otherwise lost was $18 million and that an adequate inventory accountability system does not exist. The report indicates that, although DM&S and staff office responses delineated steps that would resolve these issues, the pace and degree of improvements that will be made in the *in*patient medication distribution systems remains unresolved.

Question 29A. Have adequate steps been taken to solve these problems with respect to *out*patient medications?

Answer 29A. Our report specifically recommended that Drug Utilization Reviews of the Fee-Basis Pharmacy Program be structured to identify and eliminate the following program abuses: (a) Paying excessive drug charges; (b) using the Emergency Prescription Program when no emergencies exist; (c) obtaining duplicate prescriptions; (d) prescribing excess quantities of medications; (e) participating in program by ineligible veterans; and, (f) filling fee-basis physician prescriptions with brand name medications because authorizations for substitutions of generic equivalents were never requested.

DM&S concurred in the recommendation, and stated that the prevention of the abuses observed in the fee-basis programs will be improved through a concerted effort by the services involved. We have not yet performed any followup to assess the adequacy of implementation.

Question 29B. The report further indicates that the solution to medication handling problems would require extensive manpower, computer systems, and other resources, and that a cost/benefit study is currently being conducted to develop a reliable estimate of losses systemwide.

Question 29B(1). Is the purpose of this cost/benefit study to clarify whether or not substantial resources ought to be devoted to cutting losses and mishandling in this area?

Answer 29B(1). There is a cost-benefit study ongoing on the expansion of APPLES (Automated Prescription Processing, Labeling, Editing System). This study will identify acquisition and life cycle costs such as equipment, maintenance, and personnel to compare against benefits such as avoiding duplicate prescriptions, saving personnel time and other cost avoidance items.

Question 29B(2). When will it be completed?

Answer 29B(2). The study should be completed by September 1980.

Question 29B(3). Given the seriousness of the problems involved, are effective interim steps being taken while the cost/benefit study is being completed?

Answer 29B(3). DM&S has reported that it is continuing in its efforts to reduce the costs of fee-basis pharmacy programs by using Drug Utilization Reviews, although recognizing that substantial reductions may require computers. DM&S has issued Circular 10-80-143, "Policy on the Prescribing and Use of Medication." Further, a draft outline is being circulated to the Director's Advisory Council regarding further controls of "Controlled Substances." Essentially, it suggests that where identified audit trail problems exist in non-unit dose environments for any "Controlled Substances," the VA form, "Controlled Substances Dispensing Record" be employed as an effective means of monitoring usage in individual wards and clinics.

GAO has issued a report, dated June 24, 1980, as a followup to their 1975 report on VA's pharmacy systems. In their recent report, GAO concluded that few pharmacies have been converted to the unit dose system, and that GAO earlier recommended controls over ward stock drug dispensing practices had not been carried out. GAO's recommendations that VA implement ward stock control measures, and identify funding necessary to permit systemwide conversion to unit dose are under consideration by the Department of Medicine and Surgery.

Question 29B(4). Please forward a copy of the study and your final recommendations to the Committee as soon as it is available.

Answer 29B(4). When the cost/benefits study has been finalized by Policy and Program Evaluation, we will provide a copy.

Question 30. Your May 5 report indicates that the TARGET audits did not address the security aspects of mass computerized disclosures made from VA systems of records under the "routine use" provisions of the Privacy Act, which do not require the individual's consent to disclosure. The report noted that an audit of this area is scheduled for fiscal year 1981.

Question 30A. Did the 4 audits of security and privacy aspects of TARGET completed in February 1980, turn up any indications of possible privacy problems with respect to the disclosure of information contained in TARGET under the routine use provisions of the Privacy Act?

Answer 30A. The scope of the four TARGET audits referenced in my May 5 report did not include mass computerized disclosures. These audits concentrated on the privacy and security aspects of the system as applied to individual inquiry of the data base and unauthorized access to it. There were no indications of possible privacy problems with mass computerized disclosures. We were simply made aware, upon release of the reports, that we had not covered the entire spectrum of disclosures from the TARGET data base.

Question 30B. Because of the large number of records on individuals that are disclosed under the routine use provisions, I urge you to make the proposed audit a high priority. Is this audit being given a high priority?

Question 30C. Please provide the Committee with the results of that audit as soon as it is completed.

Answers 30B and 30C. My staff is currently developing a plan for auditing mass computerized disclosures of data from the TARGET data base. We intend to look at all aspects of such disclosures whether they are the result of requests from entities external to the VA or are necessary for expediting VA procedures. It is anticipated that this audit will be conducted early in fiscal year 1981. A copy of the final audit report will be provided your Committee upon its completion.

Question 31. I have several questions with regard to the TARGET program—specifically, TARGET "slippage", which has resulted in extensive delays in the implementation of phases one and two; the impact of this slippage and the TARGET security procedures.

On July 12, 1979, Committee staff met with Tom Acklen, Director, Advanced Systems Development Service, to discuss the status of TARGET and the slippage, of which the Committee had recently been advised. As I understand it, on June 21, 1979, 15 stations in the eastern region—all except New York, Philadelphia, Baltimore, Washington, and Atlanta—unexpectedly had to be taken off phase one because of extensive difficulties with the contractor-provided software. According to the testimony of the Chief Benefits Director, Dorothy Starbuck, at House Veterans' Affairs Committee hearings in July 1979, the difficulties were caused by "an overload in data transmissions that the software was unable to handle".

Question 31A. To what extent have you monitored or been involved in subsequent negotiations with the TARGET contractor?

Question 31B. To what extent are these negotiations likely to result in additional liabilities to the TARGET contractor?

Answers 31A and 31B. Total monitoring of all aspects of the TARGET project would require in excess of 12 full-time staff years per year through 1983 or upon completion of the full phasing-in of all functions. This level of effort, based on current personnel ceilings would restrict my ability to carry out the other requirements of my office. Based on this and the results of our initial TARGET audit I approved an audit plan for TARGET which requires the devotion of more than five full-time staff years until the completion of the project. Our emphasis is on the pre- and post-installation reviews of major phases of new development for user initiated actions and TARGET central system redesign. We are also devoting some of these resources to the areas of project management, privacy and security, documentation, and monitoring of developmental aspects of the project not scheduled for specific review.

My staff has not been involved in any negotiations with TARGET contractors. We have neither attended nor been requested to provide advice during any of the negotiations. The General Counsel and the TARGET contracting officer have initiated several actions in this area. A supplementary agreement was executed with Honeywell Information Systems on April 1, 1980 which offset the claims that Honeywell and VA had against each other through May 3, 1979. In a letter dated June 26, 1980 VA informed Honeywell that we would not pay $104,000 for which they had billed us. In addition the VA submitted a claim for over $638,000 in liquidated damages based on the delays experienced in implementing the TARGET systems between June 22, 1979 and September 10, 1979. Claims have also been

submitted for inadequate response time and system performance between November 1979 and February 1980. These claims vary from $7,200 to $14,000 per month.

Question 31C. Are you satisfied with the progress being made in overcoming the difficulties involved in the slippage?

Answer 31C. I would say that the current implementation of phase II of TARGET represents a much more reasoned approach than that originally utilized. To the extent that more regional offices have been given access to phase II functions without serious system degradation, I think that the progress made in overcoming the difficulties involved in the slippage is satisfactory.

Question 31D. Have you reviewed the revised timetable for full phasing-in of TARGET?

Answer 31D. The only printed timetable for the phasing-in of TARGET that my staff has reviewed is for the completion of phase II installation. We understand that representatives of the Department of Veterans Benefits and Office of Data Management and Telecommunications are meeting and reviewing priorities for implementation of future TARGET phases. The Office of Data Management and Telecommunications is in the process of completing work on a new TARGET management plan. This plan reportedly will be released in 4 to 6 weeks. We intend to review it and revised our approved TARGET Audit Plan as necessary.

Question 31E. With regard to TARGET security procedures, I have been advised that the employee security investigation process has been initiated. Have you reviewed the implementation of this process?

Answer 31E. The Office of Investigation, has worked very closely with the Department of Veterans Benefits and the Office of Data Management and Telecommunications in implementing the Employee Security Program. Employees have been identified in accordance with OMB Circular A–71 and applicable background investigations conducted. All that remains is the continuing identification and investigation of new employees.

Question 32. In your Semi-Annual Report for the period ending on March 31, 1980, you acknowledge that several automated data processing contracts, many of which involved end-of-year spending for both fiscal years 1978 and 1979, have generated questions in OMB and the Congress about the adequacy of the planning and the propriety of certain actions in the procurement process. This situation concerns me greatly and I am very pleased that you plan to submit a report to the Administrator with your recommendations for clarifying and strengthening ADP procurement guidelines based on reviews you have conducted of such purchases in fiscal years 1978 and 1979.

Question 32A. When will that report be available?

Question 32B. Please keep the Committee informed of the progress of that process and provide us with a copy of the completed report.

Answers 32A and 32B. This report is available and a copy will be forwarded under separate cover. The Administrator directed that steps be taken to implement all of the recommendations made in that report.

UNITED STATES GOVERNMENT

Memorandum

DATE APR 30 1980

TO Administrator (00)

FROM Inspector General (50)

SUBJ Policies and Procedures for Acquiring ADP Hardware and Software

1. Our recommendations for strengthening policies and procedures for acquiring ADP hardware and software were reviewed in draft and we received comments from the Assistant Deputy Administrator for Manpower, Chief Benefits Director, Chief Medical Director, Chief Memorial Affairs Director, Controller, Assistant Administrator for Data Management and Telecommunications, Assistant Administrator for Planning and Program Evaluation, and the Assistant Administrator for Construction. We have considered their comments and made those revisions we deemed appropriate. Most of the departments and staff offices concurred with the intent of our recommendations. Where there were serious objections to our stance we have taken particular care to reanalyze our views. In the most important of these areas, procurement, we reviewed several RFPs and talked to several agencies and vendors to determine what others were doing. Our views were vindicated by what we found. We have included an attachment which goes into slightly more detail on the subject and more specifics are available if necessary.

2. Several department and staff office heads pointed out that pending interim issues of VA circulars or other proposed procedures would carry out our recommendations. We agree in many instances. However, in some instances we did not feel that the pending issues provided sufficient guidance or detail to solve the problems which exist. We expanded our discussion of these areas to provide a fuller understanding of what we see as the central issue.

3. Some of our respondents felt we should withdraw our recommendations because they are consistent with proposed procedures. However, we think it is important to recognize that our views, independently arrived at, show the urgency of publishing these procedures. Several of them have been pending for more than a year in draft form.

4. In accordance with your request, we are arranging a meeting to discuss our recommendations with you.

A L Reynolds

ALLAN L. REYNOLDS

Attachment

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

VA FORM 2105
AUG 1979

68-178 O—80——3

POLICIES AND PROCEDURES FOR ACQUIRING
ADP HARDWARE AND SOFTWARE

1. Based on our reviews of FY 1978-79 mini-computer system acquisitions for medical programs, ongoing TARGET System development for benefit programs, and the Insurance System conversion, we believe policies and procedures governing the acquisition of ADP hardware and software should be strengthened. Current published policies and procedures are nebulous and contain insufficient control mechanisms. This has led to serious incidents of improper authorization for systems; piecemeal development and implementation; waste of large sums of money; and receipt of products which require a further expenditure of funds or personnel resources before they can be utilized. In addition, the Agency's reputation for good ADP management has been damaged with both the Office of Management and Budget (OMB) and Congress, possibly making it more difficult to obtain needed automated systems in the future.

2. We believe that the policies and procedures for ADP acquisitions should leave little, if any, leeway for interpretation. Imposition of controls in such policies and procedures, while limiting interpretation, should in no way restrict a manager's ability to manage. It should insure that all parties involved know what is expected of them to enable the timely acquisition of ADP systems which fulfill the user's needs. We recognize that special circumstances may arise which require deviations from the norm. An established authority, above the departmental or staff office level, should be empowered to grant justified deviations from the prescribed policies and procedures.

3. Our suggestions are also based on the point of view that ADP acquisitions (other than those integral to medical diagnostic and treatment equipment and some R&D activities) represent a business decision. To the extent externally regulated policies and procedures permit, VA's policies and procedures ought to provide for prudent business decision-making processes.

4. We recognize that there are various initiatives in process to rectify many of the problems discussed in the following paragraphs. We applaud these efforts and support those we and others have had some input into forming. At least two of these, interim issues to replace MP-1, part IV, chapters 1-5, have been pending for over a year. During this period the problems have continued and are beginning to receive wide-spread publicity. This can only hurt the Agency's image and delay development of critically needed ADP systems supporting our mission. We strongly urge that action be taken as soon as practicable to implement the pending interim issues or at least strengthen those areas, identified in the following narrative, which we believe essential to improved ADP management.

a. Planning. We believe that many of the problems encountered in recent ADP acquisitions could have been avoided or minimized with proper planning. In this context planning consists of several elements, with some of the most important being: justification of need based on mission requirements; total costing of the acquisition based on "life cycle costs"; a management plan

showing the various phases of development and implementation needed to make the acquisition fully operational; periodic review points at which management must evaluate the acquisition based on progress to date, refinement of "life cycle costs" and the risks involved; providing alternatives to high risk situations with an assessment of the alternatives' risks and costs; and continual updating of the management plan based on progress and an evaluation of all problems encountered or expected. A requirement for all these elements in the Agency's ADP acquisition policies and procedures should enable the VA to avoid piecemeal procurements and systems development. It should also provide management with the information needed to properly evaluate proposed procurements before and during the acquisition process.

We believe the proposed interim issues on ADP policies and procedures incorporate the planning elements which we consider most important. There are two issues which should be further clarified, however. The Assistant Administrator for Planning and Program Evaluation pointed out that "a proper definition of a 'system' must also be developed . . . " to prevent piecemeal development. He gives as an example that the DM&S mini-computer system was classified as individual systems rather than one system at several locations.

The second issue needing further clarification is the methodology to be used in determining the various components of "life cycle cost." Without a standardized methodology it will not be possible to objectively evaluate estimates of a system's cost nor will management be assured of the validity of the assumptions made in estimating total life cycle cost.

b. User Involvement. Guidance exists which defines users and their role in the acquisition process. However, we believe that further clarification is needed to insure that the intent of this guidance is realized - the acquisition of ADP systems which enables users to perform their missions most economically and efficiently. There are at least four levels of "users" within the VA. The primary users are those directly performing a task which is to be automated. They must interface directly with the system, for example: MAS clerks and laboratory technicians at a hospital; adjudicators at a regional office; timekeepers and payroll clerks at all installations. The second level or secondary users are the departmental services or staff offices which establish policies and procedures for carrying out functions at the various installations in the Agency. Examples of these are Medical Administration Service in DM&S and Education Service in DVB. The department or staff office heads are the tertiary users. They would include the Chief Medical Director, Chief Benefits Director, and Chief Memorial Affairs Director. The quartenary user is the Administrator.

Of course, there are numerous ways to define users and their level of usage of a system. It is not our intent to dictate what that definition should be. However, it is of the utmost importance that full discussion of this matter take place and clear policy be established because of the varying levels of expertise which each type user must provide to the various phases of a successful system acquisition and development. VA policies need to recognize that there are different users (user levels) and should state explicitly what their roles are.

c. Cost/Benefit Analysis. Cost/benefit analysis has not been consistently and/or effectively used within the agency. The discussion of problems in this area contained in the draft report "Overview of Agency ADP Management" is a good one. It should be used as the basis for standards against which to judge the effectiveness of revised policies and procedurgs.

We understand that the AA/P&PE is in the process of revising the policies and procedures for conducting cost benefit and cost effectiveness studies. These should be published at the earliest possible date. In addition, the recommendation to establish an effective control mechanism designed to assure compliance with policy and procedures should be implemented at the same time.

VA should explore with Congressional and OMB staffs the possibility of monetizing improvements to the delivery of services and information turn-around in cost/benefit analyses. Although this is currently unacceptable to them in justifying new systems we might be able to provoke a change in philosophy which would be to our advantage in the years to come.

d. Procurement. Contracts for software acquisition should precribe documentation standards, maximum processing times for conversion contracts, and specific testing and acceptance requirements. VA's experiences with conversion contracts over the past two years should be proof to any prudent person that the VA is taking undue risks in this area. A review of Requests for Proposal (RFP) released by other government agencies which required software development, reveals that specific requirements in these areas are not uncommon. In a recent report, "Contracting for Computer Software Development - Serious Problems Require Management Attention to Avoid Wasting Additional Millions," the General Accounting Office (GAO) points out that both agencies and vendors agreed that contracts could be improved by: (1) defining satisfactory contractor performance; (2) including specific acceptance testing requirements; and (3) specifying exact documentation requirements.

In addition to clear well defined specifications, progress payments should be tied to contractor completion of deliverables. The costs incurred basis, particularly as used in several recent conversion contracts, has left VA bearing the unreasonable risk of incurring significant expenses for incomplete or unusable products. The inclusion of specifications in a contract to insure receipt of a quality product that can be used without further expenditure of funds or other resources is essential to avoid waste.

e. Sequencing Acquisition of ADP Resources. This critcal aspect of the acquisition of ADP hardware and software could have been included in the discussion on planning. However, we considered it sufficiently important to warrant a separate discussion. We have observed instances in which hardware was delivered but could not be utilized because of insufficient trained personnel and/or no operational software. Both instances result in an expenditure of funds with no concommitant benefit being realized. ADP policy should preclude both situations.

We believe this can be accomplished by careful planning, as previously discussed, and the successful pursuit of two alternatives recommended in the report "Overview of Agency ADP Management." The first recommendation is to " . . . convert funding for . . . major ADP systems into a no-year account." This would, as stated in the report, make the funding of major ADP systems more compatible with the implementation of these systems. It would also reduce the likelihood that hardware would be obtained prematurely because of a desire to avoid losing funds which have been appropriated for one year.

The second recommendation which impacts this area involves the timely replacement of obsolete equipment. "Overview of Agency ADP Management" recommends "that VA develop a comprehensive plan for replacing obsolete equipment; . . .[and] request OMB to develop policy and provide guidance for replacement of obsolete equipment." As the AA/DM&T pointed out in his response to our recommendation much of the problem with sequencing is the result of unanticipated legislated changes or new programs. These have required new systems or modifications to existing systems which over time push the hardware beyond its capacity. VA is then in the situation of having to rush new hardware or software into use without sufficient thought to our long range needs. Timely replacement of equipment would prevent VA being hampered by an obsolete or inadequately sized ADP inventory.

f. Risk Taking. The acquisition of complex ADP systems has inherent vulnerabilities due to unexpected delays, shortfalls in expected performance, unforeseen requirements such as new legislation, and other reasonably unanticipated events. The reporting of such events, along with a clear, concise, non-technical evaluation of their impact on future plans, should be mandatory. This action is especially necessary if the event can affect budgetary projections which have been provided to OMB and/or Congress. As soon as the impact of these events has been assessed, options for minimizing them should be provided the appropriate decision makers. Specifically we want to insure that optimistic forecasts that serious problems will be overcome will be balanced by knowledge of the consequences if such forecasts turn out to be wrong. Decision makers should be given alternatives, and dates they must institute action to minimize the damage caused by unforeseen events. Contingency planning must become a reality and a continuing management function within the ADP acquisition process.

g. Benchmarking - Benchmarking and remote terminal emulation (RTE) are widely used throughout the ADP industry to validate vendors' representations of the capability and capacity of ADP systems and services. We feel that these techniques should be mandatory in all procurements where Federal Procurement Regulations (FPR) permit. Where the FPR do not permit the use of these techniques, alternative validation methods should be required. We would suggest that alternative methods be researched and prioritized in order of mandatory usage according to their degree of effectiveness in predicting performance.

Where there are special considerations which would mitigate against the use of the mandatory validation techniques we think the General Services Administration's help should be sought in evaluating alternative techniques. The technique chosen should be fully justified and approved by an appropriate authority.

h. Controls. Policies and procedures are only words on paper without effective controls. As stated earlier ineffective control mechanisms have led to a variety of ills in ADP management including improper approval levels; piecemeal development; and receipt of products which require a further investment to become operational. In this day of increasing Congressional oversight and tighter budgets VA can no longer allow such actions to take place.

We believe that the control mechanisms in the two proposed interim issues on ADP policy and procedures; OI 1, part VI, chapter 11; and the proposed redraft of MP 1, part 2, chapter 20 should stem the excesses noted above. However, the proposed documents are not in effect nor have they been tested in the real world. We believe there is an urgent need for publishing these procedures as soon as possible. We also believe that formal evaluations of these policies and procedures should be scheduled no later than one year after their publication and one year after publication of the results of the first evaluation. This should be sufficient time to test the effectiveness of the control mechanisms, make the necessary modifications, and test the modified mechanisms. Only with constant oversight can you be assured that the intent of policies and procedures is not being subverted.

i. Accountability. Increasing the accountability of individuals who play critical roles in ADP systems acquisitions should be a key issue for discussion within the Agency. Wherever possible the plans, commitments, and other projections made by managers should be used as critical elements for assessing the performance of these individuals. Care must be taken however to insure that the elements selected as critical are within the individual's scope of authority and totally under his/her control. There must be a means of assuring better planning, more consideration of inherent risks, and earlier attention to and aggressive actions taken on problems. We must insure however that we do not penalize one manager for another's failure to perform responsively.

j. Accounting for the Investment of ADP Resources. With the increasing tendency towards budget restrictions VA must develop an effective cost accounting system for ADP resources. Top management must have a feel for current allocations of resources that permit a realistic understanding of systems -- their status, use, use trends, costs, and cost trends. With fewer dollars to spend we must have a means of determining where they are being spent and whether we are obtaining maximum utilization from them. We think it is of the utmost importance to consider initiation of a charge-back system or some other cost accounting tool for the Agency by fiscal year 1982.

Attachment

PROCUREMENT

It is becoming a common practice for Federal agencies to obtain computer programs (software) from private firms by contracting for software development. Some reasons for contracting for software development are: insufficient staff, lack of staff expertise, lower cost, and OMB Circular A 76. While many of the contracts result in delivery of operational software, too many contracts result in large cost overruns, lengthy delays and agency dissatisfaction with the end product.

To determine how other agencies approached contracting for software, a review of Requests for Proposals (RFP) and applicable General Accounting Office (GAO) reports was made. In addition discussions were held with other agencies and vendor personnel to determine vendor attitudes towards specific requirements.

We reviewed 10 RFP's which had been developed by other federal civilian agencies, Department of Defense (DOD) components, and one state agency. The RFP's covered proposed acquisition of hardware, software, conversion of existing software, and allied documentation. The review revealed that the requirement for a benchmark using agency supplied data was common. These benchmark requirements, if satisfied, would demonstrate not only the performance of the equipment but also the operational capability of the proposed software. In 9 of the 10 RFP's execution time of the programs was specified as a mandatory item. One RFP not only specified program execution time but also the number of programs that would be executing in a multiprogramming mode. In discussing a recently awarded contract for hardware and software conversion with a representative of GAO, it was learned that the requirements were even more stringent. The RFP specified processing time and that the programs would be written in COBOL-74 without vendor extentions. Also, if vendor extentions were used, the vendors would be required to convert the programs to straight COBOL-74 at the termination of the contract. The provisions of the RFP were upheld by General Services Administration, National Bureau of Standards and the GAO Legal Counsel. The RFP attracted competitive bidders and a contract awarded.

GAO examined nine cases of software development. Only one of the nine yielded software that could be used as delivered. The combined total cost and development time of the nine cases increased from an estimated $3.7 million and 10.8 years to an actual of $6.7 million and 20.5 years.

Prudent management dictates that total systems requirements be documented and expressed in the RFP as mandatory. Once the contract has been awarded, vendor performance must be monitored throughout its cycle by well qualified technicians. Vague contracts coupled with insufficient ineffective monitoring can lead to the delivery of unacceptable products which require the expenditure of additional funds and time.

Three vendors were interviewed. The consensus of opinion among them was that the RFP should be very specific about requirements and performance criteria. Well developed, technically sound specifications and effective management controls will not deter a competent vendor from accepting the risks of developing the desired end product.

Experience has shown that the cost of obtaining an acceptable end product will be paid. The choice is whether it will be paid up front, based on clearly written specffications, or downstream as a result of long time delays, revising and optimizing an inadequate end product, and maintaining or modifying poorly documented systems.

UNITED STATES GOVERNMENT

Memorandum

DATE: MAY 29 1980

See List Below

FROM: Deputy Administrator (001)

SUBJECT: Policies and Procedures for Acquiring ADP Hardware and Software

1. The Inspector General briefed the Administrator and selected members of his staff on May 6, 1980, on the above subject. At the end of the briefing, the Administrator gave direction as to who should take the lead roles on implementation of certain recommendations and procedures. In this respect, the Administrator asked me to be the control point to authorize justified deviations to the basic guidelines on acquisition of ADP equipment. He also asked me to take the overall lead role on implementation of the matters mentioned below.

2. The Associate Deputy Administrator also provided the Administrator with an overview of the present ADP management environment and made several recommendations for improvement. Most of the recommendations are consistent with those of the Inspector General or have been addressed in the Administrator's Numbered Memorandum 00-80-6 dated May 16, 1980. This memorandum also incorporates those recommendations not addressed by the Inspector General or by Memorandum 00-80-6.

3. Within 30 days, the two Interim Issues now pending in the Office of Data Management and Telecommunications should be printed and distributed. The Assistant Administrator for Data Management and Telecommunications has the lead role, with the Assistant Administrator for Planning and Program Evaluation having a secondary role.

4. We need a new definition of "system" as it relates to ADP in order to prevent piecemeal development. The lead role in establishing this new definition is assigned to the Assistant Administrator for Planning and Program Evaluation, with the Assistant Administrator for Data Management and Telecommunications and the Controller having a secondary role.

5. We need to redefine the various levels of ADP users and their respective roles in system acquisition and development. Responsibility for the new definition is assigned to the Assistant Administrator for Planning and Program Evaluation who will coordinate the new definition with concerned elements of Central Office.

6. Cost/benefit analyses, in times past, have not always been consistently and effectively used. We should explore the possibility of monetizing improvements to service and timeliness of information. The Assistant Administrator for Planning and Program Evaluation has the lead role for this exploration, with the Controller having the secondary role.

7. There is a need for an ADP Training Plan which encompasses Agency requirements for ODM&T and user personnel. The Assistant Administrator for Data Management and Telecommunications has the lead role, with Department and Staff Office heads having secondary roles.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

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See List Below

8. Software contracts should prescribe documentation standards, processing times, and specific testing and acceptance criteria. Progress payments should be tied to deliverables in a manner that appropriately balances risks between the Agency and the contractor. We should also have a policy which provides for the sharing of risks. The insurance conversion, which anticipated 100% of the risk factor being with the VA and none to the contractor, is an example, of what we should avoid. The Assistant Deputy Administrator has the lead role in this effort.

9. We should attempt to have multi-year funding for major ADP systems to make funding of these systems more compatible with their implementation. The Controller has the lead role.

10. We need a comprehensive plan for timely replacement of obsolete ADP equipment. Responsibility for development of this plan is assigned to the Assistant Administrator for Data Management and Telecommunications.

11. We should set forth the risks which are involved as we proceed into new applications of ADP and assess their impact on future plans. Options for minimizing such risks should be reported to top management. The Assistant Administrator for Planning and Program Evaluation has the lead role in this endeavor, with the secondary role being assigned to the Assistant Administrator for Data Management and Telecommunications.

12. Benchmarking should be mandatory where Federal procurement regulations permit. As to this, our policy manuals need to be clear. The Assistant Deputy Administrator has the lead role.

13. An evaluation of the effectiveness of controls established in the interim issues on policies and procedures should be made no later than a year after their publication. The Assistant Administrator for Planning and Program Evaluation has the lead role.

14. The Agency needs to determine means of tying pay to performance of individuals who play key roles in ADP acquisitions. The Assistant Administrator for Personnel has the lead role.

15. We should consider whether or not we can have a better accounting system with respect to investment of ADP resources. We should consider initiation of a charge-back system or other cost accounting methods by FY 82. The Controller has the lead role.

16. A policy memorandum is needed to clarify, among Departments and Staff Offices, responsibilities for coordination with external agencies. The Assistant Administrator for Planning and Program Evaluation has the lead role.

17. Attached to this memo are the notes used by the Inspector General during his briefing of the Administrator.

See List Below

18. Written progress reports from each "lead role" participant are requested by COB June 19, 1980.

RUFUS H. WILSON

Attachment

Addressees:

Assistant Deputy Administrator (003)
Assistant Administrator for Personnel (05)
Assistant Administrator for Planning and Program Evaluation (07)
Assistant Administrator for Data Management and Telecommunications (30)
Controller (04)

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ATTACHMENT

POLICIES AND PROCEDURES FOR ACQUIRING ADP HARDWARE AND SOFTWARE

Introduction

- o Guidelines for acquisition of ADP Hardware and Software should be strengthened
- o Need explicit policies and procedures to limit interpretation
- o Provide control point to authorize justified deviations
- o Various initiatives in process should be implemented without delay.

Planning

- Proposed ADP Policies and Procedures incorporate important planning elements
  - Justification of need
  - Life cycle costs
  - Management Plan
  - Management Review points
  - Continual updating of management plan
- Two issues need further clarification
  - Definition of "system"
  - Methodology for determining components of "life cycle costs"

User Involvement

- Various levels of users
- Policy must recognize and state each role explicitly

Cost/Benefit Analysis

- o Not consistently and effectively used
- o Policies being developed should be implemented
- o Explore possibility of monetizing improvements to service and information

Procurement

- o Contracts should prescribe documentation standards, processing times, and specific testing and acceptance criteria.
- o Progress payments should be tied to deliverables.

Sequencing Acquisition of ADP Resources

- Multi-year funding
- Timely updating of ADP equipment inventory

Risk Taking

- Reporting risks required
- Alternatives presented to management

Benchmarking

- Should be mandatory where FPP permits

Controls

- Must be effective
- Implement proposed interim issues
- Test effectiveness of new control mechanisms

ACCOUNTABILITY

- o AGENCY NEEDS TO DISCUSS MEANS OF TYING PAY TO PERFORMANCE IN THIS AREA

ACCOUNTING FOR THE INVESTMENT OF ADP RESOURCES

- o CONSIDER INITIATION OF A CHARGE-BACK SYSTEM OR OTHER COST ACCOUNTING BY FY 82

68-178 O—80——4

Question 32C. I also understand that you plan an audit of end-of-year procurement for fiscal year 1980 and to look further into OMB's specific concerns about year-end buying in fiscal year 1979. Please keep the Committee informed of your findings and recommendations with respect to these matters.

Answer 32C. At the direction of the Administrator, a special task force study was conducted to reply to observations or allegations made by OMB and OFPP regarding year-end spending on ADP related contracts. As a result of reviewing the task force report, we concluded that certain allegations required additional investigation. We are conducting a review in response to specific allegations of leaking of information, favoritism and improper use of SBA 8(a) contracts. The GAO, in response to the request of the Subcommittee on Special Investigations, House Committee on Veterans Affairs, is also reviewing fiscal year 1979 year-end spending. To preclude duplication of effort, we have been cooperating with the GAO review team and have responded to their requests for information and have been sharing our findings. We are also in the process of developing an audit proposal for reviewing fiscal year 1980 year-end spending. This proposal will address the extent of competition, contract procedures, and the effectiveness of the Agency's year-end spending controls.

Question 33. On pages 1 through 12 of your Semi-Annual Report, you indicate that your audits have identified deficiencies in the VA's billings and collections for medical care cost recovery and that 5 audit reports indicated problems in this area, such as the lack of billing in cases where ineligible veterans or emergency patients received care. You also indicate that the Administration has proposed legislation, S. 759, to facilitate such recoveries.

Question 33A. What is the dollar amount of the potential recoveries for which collection action was not taken in the 4 VA medical centers that were audited?

Answer 33A. Potential recoveries of $51,442 were identified in routine cyclical audits at four medical centers. This represents 31 different claims for which the VA had not billed either an ineligible patient, Medicare, or an insurance carrier.

Question 33B(1). What recommendations have you made to improve the VA billing and collection effort?

Answer 33B(1). Since these were facility audits of individual medical centers rather than a program audit of medical care cost recovery, the recommendations were made to specific medical centers. They included:

(1) That eligibility control procedures be strengthened to ensure that: (a) All ineligible recipients of medical care are billed; and, (b) medical records and locator index cards are clearly stamped ineligible.

(2) That management ensure collection action be initiated to Medicare for all identified ineligible hospitalization claims.

(3) That controls be established to ensure that: (a) All applicants for medical treatment complete the question regarding insurance coverage on the VAF 10-10 except when applying for treatment of a service-connected condition; and, (b) whenever an applicant acknowledges having insurance coverage, medical center personnel follow through with the insurance company to determine whether the applicant's policy specifically excludes reimbursement to the VA. If not excluded, submit a claim for reimbursement.

Question 33B(2). If it assumed that S. 759 will not be enacted—and I do not believe it will be—would your recommendations change? In what way?

Answer 33B(2). No, our recommendations wouldn't change if S. 759 is not enacted. The Department of Medicine and Surgery has had longstanding requirements to attempt collection action on all cases. This policy was reiterated in a special letter to all VA medical facilities on March 5, 1980. Our audit findings and recommendations were to those facilities which were not complying with these established requirements.

Question 33C(1). Have you received the procedures used in VA medical centers to account for the amounts of these receivables and, if collected, their disposition?

Answer 33C(1). During most of our medical center audits we review the procedures used to account for the amounts of these receivables and the disposition of any amounts collected.

Question 33C(2). Please describe those procedures and any discrepancies that you have found.

Answer 33C(2). For each ineligible or emergency patient the fiscal service at the medical center establishes an account receivable in the general ledger account. The receivable remains in the general ledger account until the debt is collected, waived, or terminated as uncollectable. Amounts collected are transferred to the U.S. Treasury. We have not found any significant deficiencies in the accounting of debts and the disposition of collections, although, as mentioned above, we have found deficiencies in billing and collecting procedures.

Question 33D. Have you noted any difference in the extent of potential re-recoveries that are made in terms of the differing sources—such as workers' compensation carriers, auto liability insurance carriers, or Medicare?

Answer 33D. Our medical center audits have not covered the question of whether recovery efforts are more successful with some kinds of insurance carriers than with others.

Question 34. A recent GAO report, "Problems in Administering the Servicemen's Group Life Insurance Program in the Ready Reserve" (FPCD-80-45), issued May 1, 1980, discusses the difficulties experienced by the VA in collecting certain sums due by law from the Defense Department for Servicemen's Government Life Insurance premiums. Section 769(a) of title 38, United States Code, requires the services to deduct from their appropriations and forward to the VA sufficient funds to pay the premiums for all Ready Reservists covered by SGLI. According to this report, the Marine Corps and the Coast Guard are in compliance, but the Departments of the Army, Navy, and Air Force forward only the premiums actually collected and not the total amounts due, which would include the unpaid, overdue premiums. The service departments not in compliance argue that the SGLI program is intended to be self-supporting and should not be subsidized by them. I note that GAO has found no threat to the SGLI program from this interagency dispute.

Question 34A. What effort have you made to assist the VA in collecting the amount due?

Answer 34A. There is little this office can do to assist in collecting the amount due. Actual collection is not within the authority of this office. The question becomes, then, what can we do to press for compliance with the law that is in effect. We are advised that VA and Department of Defense (DOD) representatives will be meeting to resolve the issues brought to light in the GAO report. We certainly intend to monitor the progress of these discussions, the collection action taken, and to see that these issues are resolved at the appropriate executive branch level. If it becomes clear that an additional interagency inquiry is necessary we will be ready to propose such an inquiry to the audit arms of the related military services.

Question 34B. The GAO recommends legislation to solve the difficulties created by the nonpayment of premiums. What is your position on the GAO's recommendation?

Answer 34B. We note that GAO has identified deficiencies in the systems of some services in accounting for, billing, and collecting premiums. Provision in the law for termination for nonpayment of premiums would require administrative action on the part of these same services to identify and notify the Veterans' Administration of insureds whose have not paid premiums. This calls for development with DOD of sound administrative procedures to implement any such change in the law. A legal question raised by VA's General Counsel must also be resolved: "Will a termination provision for nonpayment of premiums negate the automatic coverage feature of the program?" We intend to remain informed of any alternatives developed from discussions with DOD and to press for the most economic and timely solutions. We will also review any proposed legislation to insure the continued efficiency and economy of the VA insurance system.

Question 35. With respect to your audit recommendation in connection with non-service-connected health-care services, you state, on page 4 of your testimony, that the Deputy Administrator has directed that collection action be instituted against employees who have abused the system. What is your estimate of the dollar amount of the possible recoveries?

Answer 35. Our audit report recommended collection action against 465 employees. The potential amount to be recovered is $682,913. However, the actual amount collected may be less because the employees concerned will have the right to disagree with the collection action, to submit evidence to support their position, and to appeal adverse actions to the Board of Veterans Appeals.

Question 36. Beginning on page 4 of your statement, you discuss the issue of the VA sharing specialized medical programs with other Federal or community facilities. On this issue, the Committee has received information from a variety of sources indicating that, at least with reference to some programs at some stations, such as CAT scanners at some medical centers that do not have such equipment, the amount of fees paid by the VA to facilities in the community for the use of private specialized services is so great that, were the funds applied to the purchase of the equipment at the VA facility, it would be possible to pay the entire cost within 1 to 2 years.

Question 36A(1). In the course of your work in this area, did you find this to be true, for example CAT scanner services at the Bay Pines VA Medical Center in St. Petersburg, Fla.?

Answer 36A(1). The cost effectiveness of using private specialized services was questioned in our December 31, 1979 audit report on the VA Medical Center, Lexington, Ky. The services involved were CAT scans and radiation therapy. The costs of CAT scans provided the medical center under a sharing agreement with the University of Kentucky were $200,542, or 43 percent of total fiscal year 1978 sharing obligations and were increasing. Fiscal year 1978 cost associated with radiation therapy services purchased from the University were $125,000 or 27 percent of total sharing obligations. No cost analysis studies were available comparing the in-house costs of providing CAT scan capability versus the sharing agreement costs and, except for Laboratory Service, no documentation was available of any cost studies by any other medical service. The report recommended that additional cost alternative benefit analysis studies be conducted for sharing agreement resources, especially in regard to CAT scans. In concurring with the recommendation, the medical center director stated that critical space shortage and estimated construction, equipment, and staffing costs of over $1 million made it extremely unlikely that VA Central Office would entertain a proposal that the medical center provide radiation therapy servies.

In a November 2, 1979, status report the Department of Medicine and Surgery stated that a completed cost benefit study of CAT scan services at Lexington concluded that a VA owned scanner would be more economical and that Lexington had been selected to receive CAT scan equipment. On July 22, 1980, a Department official stated that a CAT scanner has been purchased for Lexington but has not yet been installed.

Our June 20, 1980, audit report on the VA Medical Center, Bay Pines, Fla., did not include a discussion of CAT scan services purchased by this facility. However, Department officials stated that the facility purchases a limited number of CAT scans (about 12 scans per quarter in fiscal year 1980) and, as a result, does not meet the established criteria for acquisition of CAT scan equipment.

Question 36A(2). (If yes) At how many stations did this situation exist and as to what programs was it most pronounced?

Answer 36A(2). Between April 1, 1979, and June 30, 1980, audit reports were issued on 60 medical centers, including Lexington. We found no indications that similar situations existed at any other station where the audit scope included a review of specialized medical program operations and sharing agreements (about 40 stations).

Question 36B. Would you please assure that, in all future audits of VA medical centers, this specific point is evaluated and that your reports of audits include relevant findings on this issue and that those findings are transmitted to the Committee?

Answer 36B. To insure that the issue described in Question 37 is fully considered, we will direct our Field Offices of Audit to review the use of community resources during all medical center audits done in fiscal year 1981. We will use the outcome of experience gained during 1981 as a basis to determine the worthwhileness of continued mandated coverage of this subject versus other alternative subjects. We will provided you with copies of all audit reports where we find that purchase of services from outside sources significantly exceeds the costs of an in-house capability.

Question 37. You appended to your written statement a breakdown as to minority and female employment by grade level professional and administrative staff. However, this breakdown is very general and appears to include women and minority members in a single category. Please provide breakdowns according to race, Spanish surname, and sex and the positions and the GS levels for persons in each group.

Answer 37.

OFFICE OF INSPECTOR GENERAL

Grade	Black	Spanish surnamed	Asian American Pacific Islander	Female	Total *
13	0	0	0	1	1
10	0	0	0	1	1
9	0	0	0	1	1
Office of Investigations					
14	1	0	0	1	2
13	1	1	0	1	3
12	1	1	0	1	3
11	2	2	0	0	4
9	0	0	0	2	2

OFFICE OF INSPECTOR GENERAL—Continued

Grade	Black	Spanish surnamed	Asian American Pacific Islander	Female	Total [1]
Office of Audit:					
15	2	0	0	3	4
14	2	0	0	5	6
13	2	0	3	7	11
12	20	0	1	13	27
11	11	1	3	10	19
9	5	0	0	7	9
7	2	0	1	3	4
Risk analysis staff:					
13	0	0	0	2	2
8	0	0	0	1	1
7	0	0	0	1	1
Total	49	5	8	60	101

[1] This column represents the total persons employed at the grade levels. It is frequently less than the combined total of the columns since some people (e.g., black female) are counted in more than one column.

Question 38. Section 4(a)(2) of the Act requires the IG to review existing and proposed legislation and regulations relating to programs and operations and make recommendations concerning the impact of such legislation or regulations relative to economy and efficiency and any potential for fraud and abuse.

Question 38A. Do you always have a timely opportunity to carry out this responsibility?

Answer 38A. We are frequently given very short deadlines (2–4 days) to comment, particularly on legislation. Consequently, we must rely on recall of specific audits, investigations or risk analyses to determine whether there are related/similar problems relative to economy and efficiency or any potential for fraud or abuse.

Question 38B. Have your recommendations received full consideration within the executive branch?

Answer 38B. Our recommendations are given thorough review by the General Counsel in VA. As shown in the Semi-Annual Reports, some of our suggestions do impact the final regulation or the VA position on legislation.

Question 39. Do you believe that the hotline—by allowing employees an anonymous opportunity to air grievances and report alleged cases of fraud and abuse—contributes to or detracts from employee morale?

Answer 39. Because the VA hotline is a recent addition to this Agency, no study has been done on its affect on employee morale. Such a study appears premature at this time. Indications received from employees and the perceptions of those working with the hotline tend to support the conclusion that the overall effect is beneficial.

Employees' morale seems to benefit from knowing that they have someone to whom they can talk to confidentially. A number of the callers have expressed fears, justifiable or not, of retaliation if they make allegations through the normal organizational structure and process. Because employees are usually aware of problems in their immediate work area, it follows that they may be reluctant to proceed through normal channels if the charges seem serious. Therefore, the hotline is a viable means for them to relay their allegations.

There is considerable concern, particularly with managers at VA medical centers, about the hotline acting on anonymous allegations, or that they cannot "face their accuser." Consequently, there is a strong feeling among some managers that anonymous hotline complaints should not be acted on.

Question 40. I note from your latest Semi-Annual Report that your office is active in various activities to improve coordination and cooperation among Federal, State, and local audit groups and Inspectors General of other departments and agencies.

Question 40A. Is there a formal interdepartment and interagency organization of Inspectors General?

Answer 40A. In May 1979, the President created the Executive Group to Combat Fraud and Waste in Government which is chaired by the Deputy Attorney General and vice-chaired by the Deputy Director of Office of Management and Budget. The Group's membership includes all of the statutory Inspectors General, the Deputy Director of the Office of Personnel Management, the Special Counsel of the Merit Systems Protection Board and other representatives of various other Federal agencies. The executive committee of the Group meets monthly.

Until now the main efforts of the Group have been aimed at developing more effective procedures and better trained personnel to deal with fraud and waste, and dealing with problems that go beyond the capacity of individual agencies by sharing the expertise of all the agencies. Among other efforts the Group has organized successful orientation sessions for the Inspectors General; is supporting interagency Inspector General initiatives such as GSA's audit of furniture management and control practices; and is providing IG-level advice to the Department of Education team developing the Inspector General for that new department. Committees, each chaired by an Inspector General, are focusing on training, staffing, management and organization; legislative and regulatory issues; audit and information system concerns (which I chair); and enforcement. OMB and Justice staff are working directly with the executive committee, as well as providing staff support for the Group as a whole.

The Executive Group has generated an effective communications network among the Inspectors General; the IG's now get together regularly for working luncheons; have organized and conducted a conference at the FBI Academy in Quantico, Va., and have discovered the value of sharing ideas and problems with each other on a regular basis.

Question 40B. To what extent has your office participated in joint or cooperative training programs with other Inspectors General? Please indicate the types of training concerned, the dates of such programs, the other IG offices involved, and the number and types of VA IG personnel who participated.

Answer 40B. Prior to the formal establishment of the Executive Group, there was an orientation and training session attended by all the IG's and chaired by the Attorney General. This was followed in April 1979 by a 3-day training session for all of the IG's and their top staff at the Federal Executive Institute. Another session for all of the IG's took place in November 1979 at the FBI Training Academy in Quantico, Va.

The Office of Audit sent 2 auditors to a one-week program in May 1980 entitled "Auditing Schedule Contracts (Multiple Award Contracts)" which was sponsored by the General Services Administration and attended by representatives of other IG offices. We are also sending 3 senior managers to a 2-week program in October 1980 at the Federal Executive Institute. This program sponsored by the Executive Group is specially designed for senior members of other Offices of Inspector General. In addition, the Assistant Inspector General for Audit is chairing an interagency task force to establish short and long term goals for the development of basic training for Office of Inspector General audits.

Although not IG-sponsored, during the last year 25 investigators participated along with other IG personnel in the 2-week White Collar Crime Seminar at the Law Enforcement Training Center, Glynco, Ga.

Question 40C. In addition to the joint VA/HUD audit and investigation in Puerto Rico, what other joint or interdepartment or interagency audits and investigations does your office plan?

Answer 40C. Other joint or interdepartment or interagency audits and investigations include the following:

1. A project led by DoL and involving VA, DoT, USDA, HHS, the Navy, Air Force and Postal Service to audit the administration of the Federal Employees (Disability) Compensation Act in order to recommend and implement cost saving and abuse prevention measures and recommend legislative changes.

2. A project led by GSA and involving all OIG's to review agency requests for additional space, the current inventory of vacant space and GSA's responsiveness to agency space needs.

3. A project led by GSA and involving all OIG's, plus the Department of Defense, to review the quality and inter-agency usage of debarment information and processes as they relate to the procurement of goods and services by the Federal Government.

4. A similar review of department information, usage and processes by USDA (FmHtA), VA and HUD to develop a consolidated list of participants in federally assisted housing programs (developers, contractors, mortgage brokers, etc.) who have been the subject of negative determinations of any one of the three agencies.

5. In response to OMB's recent letter concerning management control of consulting service contracts and improvement of Agency procurement practices, the Department of Housing and Urban Development has taken the lead role in developing a standard governmentwide audit guide for these areas. The VA's Office of Audit is supporting HUD in this effort and has provided a senior auditor to work with HUD's task force.

6. At the request of the Administrator of General Services, the Office of Audit has established a liaison with the Information Retrieval and Distribution Branch of the

National Archives and Records Service (NARS) for the purpose of helping to plan and effect an inspection of the VA's micrographics management. There will be representatives of audit staffs from other agencies as well. The objective of this group is to develop a standardized audit program which will enable each agency to review its own micrographics management for cost benefits, program results and compliance with FPMR 101-11.9.

Question 40D. Are such joint efforts effective?

Answer 40D. Such joint efforts have proven to be effective and it should be noted that we report these efforts in our Semi-Annual Report. As a result of these efforts, agencies have been able to share ideas, information and resources to better address specific targeted problems which cross agency lines. These significant cooperative efforts have occurred as a direct result of the Inspectors General working together.

Question 41A. Please comment on each of the observations and suggestions made by GAO on pages 7 and 8 of its written testimony regarding your office's handling of allegations of fraud, abuse, waste, and mismanagement.

Answer 41A. GAO talks about complaints which we receive from a variety of sources including the employee hotline, complaint mail (to the Administrator or the Inspector General), department and staff offices, other agencies, and from employees who contact auditors or investigators during field work. Their criticism is that we do not have a system which accounts for the total number of allegations.

Question 41B. Please describe the procedures and standards that you have prescribed to screen such allegations to determine whether an investigation or other followup by your office is warranted.

Answer 41B. We do maintain very detailed accounting on hotline complaints. We provide a less detailed accounting for complaint mail, much of which is not related to the operations of this office. Our controls for these two primary sources of complaints are as follows:

Hotline.—All hotline contracts accepted are given a control number. We frequently advise callers with personnel complaints to go through established channels, that is, Personnel Office, union representative. When this is done, we do not enter their complaints into the hotline system. All accepted hotline contacts are entered onto a log showing control number; date received; category code; brief description of the nature of allegation; location; Department, staff office, service or program involved; whether the complainant had previously reported the allegation through channels, whether the complainant wanted to remain anonymous; who allegations were referred to for handling, that is, audit, investigation, department or staff, disposition and date closed. All hotline contacts are referred in writing to the appropriate department or staff. When the hotline complaints are considered minor, or not a hotline matter, they are referred for handling but no reply is requested. On all other hotline referrals, a reply is requested. When received, the replies are reviewed for responsiveness. As necessary, there is followup correspondence to obtain additional information. Referrals to us from the GAO are also handled under these same controls.

Hotline allegations are reviewed by the Risk Analysis Staff for importance. Since anonymous letters cannot be followed up, they are processed solely on the content of the facts and potential seriousness of the allegations in the letter. However, a reasonable effort is made to identify telephone complaints in order that they may be contacted to answer any subsequent questions or provide more specifics. If the complainant wants to remain anonymous to the Hotline and the initial indication is a serious complaint, then they will be asked to call back at a mutually agreeable time to provide any needed clarifications. Complaints of isolated instances of abuse or allegations of waste or mismanagement which are not of major magnitude are referred to the appropriate department or staff office for review and corrective action. Complaints implying serious personnel misconduct, or civil or criminal wrongdoings are referred to the Assistant IG for Investigations. Those allegations of major mismanagement or serious shortcomings in program controls are referred to the Assistant IG for Audit.

Complaint mail.—Complaint mail, as well as in person and telephonic complaints from many diverse sources, are received by the Office of Investigations. While the complaint mail is logged in, we do not necessarily log in complaints received through other channels. These sources include employees, veterans, private citizens, service organizations, private non-VA organizations, unions, members of Congress, other agencies, Federal and local law enforcement agencies, and anonymous sources. Upon receipt of complaints, as indicated, preliminary investigative inquiries and/or discussions with VA officials or others may be held prior to a decision on disposition. Each complaint is personally reviewed by the Assistant Inspector General for Investigations or the Deputy Assistant Inspector General for Investigations and a decision made to initiate an investigation, refer the matter to the appropriate VA

element and monitor the action taken, or simply refer the matter for handling without asking to be advised. There is a long-standing formal system in place for following up and insuring the adequacy of investigations and action taken by non-IG elements by the VA. Frequently, serious complaints, such as those by disturbed individuals involving threats, are handled immediately by the Office of Investigations and involve the coordination of rapid development of information and action by various elements of the VA and other agencies. Further, complaint investigations initiated by other elements of the VA which were not matters referred by the Office of Inspector General are reviewed by the Office of Investigations for adequacy and, depending on the status of the matter, a determination of whether further IG investigation is indicated.

We do not agree that a total accounting of all allegations is worthwhile. Some are minor matters; others are matters not within the duties and responsibilities of this office. We do believe there is potential value to be gained by a comprehensive system of accounting for complaints and we have been exploring the establishment of a complaint center as a single source to carry out the recoding of hotline, complaint mail and other source information in which this office has an interest.

Question 41C. What procedures have you prescribed to guarantee the anonymity of employees using your hotline and to protect against reprisals all employees who have made complaints to your office?

Answer 41C. When information from a hotline contact is referred to the appropriate department or staff, all personal identifiers are removed. Sometimes it is necessary to "blank-out" part of a letter to remove the personalizations that make it possible to identify a person. No hotline contacts are referred containing the employee name or other identity without the expressed permission of the employee, usually in writing.

The identity of a complainant wishing to remain anonymous is not released outside the Office of Inspector General unless the Inspector General determines such disclosure is unavoidable during the course of an investigation or it is later determined that the complainant himself knowingly and willfully presented false evidence and action against the complainant may be warranted. The circumstances of any alleged reprisals against complainants are thoroughly reviewed and full investigations conducted when indicated. Recommendations are made for any necessary corrective or disciplinary actions. There is a long-standing provision in VA Manual MP-1, part I, chap. 2, para. 204.07 which provides for protection against retaliation.

Chairman CRANSTON. I understand that you and the Chief Medical Director have discussed the possibility of establishing a Medical Inspector Office within D.M. & S. which would be organizationally responsible to the Chief Medical Director. This office would have responsibility for reviewing all matters relating to quality of care issues and the competency of D.M. & S. professional staff.

What is the current status of that proposal?

Mr. REYNOLDS. The proposal has been submitted to the Administrator for approval. I am told that in principle it is going to be approved but there were a few minor points that were to be straightened out before it is in fact approved.

Chairman CRANSTON. One of the most important aspects of the Office of Inspector General is its independence. The committee is very concerned that any proposal to transfer functions to D.M. & S. for which the Inspector General is currently responsible may compromise the Inspector General's independence. Would you comment on these concerns?

Mr. REYNOLDS. Yes, sir. The creation of an Office of Medical Inspector along the lines intended here was my suggestion actually. We first identified the fact that we were beginning to get into problems as early as February 1979.

In March of 1979, I discussed with the Administrator the problems that we saw that were already there, the additional ones that we saw coming. The issue revolved around the fact that very frequently, when we got into an investigation in particular, less

frequently in an audit, we would get into a matter that overlapped between an area that clearly was within the expertise and capability and jurisdiction of my office and an area where we lacked the expertise to actually address.

An example would be what we were finding in Manhattan, which was one of the early cases we had a lot of difficulty with. The allegations in Manhattan said that people were not following the prescribed procedures, namely that was lack of adequate supervision and that there was a lack of informed patient consent. Both of these are within the expertise and we feel the responsibility of my office. But the latter part of the allegation was that patient care was affected by these activities. That is really outside the expertise of my office and my feeling is that the Inspector General Act does not, per se, mandate the entry of my office's activities into the patient care field.

Therefore, the idea was that the patient care aspect of this sort of thing should be covered by the Department of Medicine and Surgery which has programmatic responsibility for patient care.

Chairman CRANSTON. In your opinion, may such a transfer of functions be accomplished without violating provisions of the Inspector General Act?

Mr. REYNOLDS. Yes, sir. In fact, I don't see it as a transfer of functions. I think the problem we have today is that we have been addressing these sorts of situations on a totally ad hoc basis. We have been working with the Department of Medicine and Surgery and they have loaned us doctors to get into these sorts of problems.

It is not so much a transfer of functions as an increase in the capability and independence within D.M. & S. to address the quality of care issue.

Chairman CRANSTON. If authority were vested in a Medical Inspector Office within the Department of Medicine and Surgery for specified matters, D.M. & S. would in effect be investigating its own house. Would you have any reservations regarding the viability of such an in-house audit or investigation procedure?

Mr. REYNOLDS. Generally, no, but I think there are specific instances, and again I would go back to Manhattan, that it would be unwise for D.M. & S. to use their own people. The Manhattan situation was widely covered in the newspapers and there was an inference from the start that D.M. & S. would not look at its own house. In that case, it would have been preferable for the Medical Inspector, for example, to arrange for outside physicians, non-VA physicians in my judgment, to look at that case.

Chairman CRANSTON. How do you believe the general public would view such audits or investigations?

Mr. REYNOLDS. I don't know that I could really speak for the general public. I think the press would tend to question the independence of D.M. & S. looking at itself if it became an issue that received a lot of public attention through the press. I think in that case, the Department of Medicine and Surgery would be well-advised whenever that happens to look outside the VA for this capability.

Mr. STEINBERG. Do you have any estimate or has any estimate been prepared of the resources that would be necessary for

D.M. & S. to undertake this responsibility? I take it you are not proposing a diminution of your resources?

Mr. REYNOLDS. Not at all nor am I proposing to give up anything clearly within our charge in terms of addressing fraud, waste, and mismanagement. No, I do not have an answer to what the resource requirements would be. Our experience is that the types of cases where we need to work directly with doctors to resolve a case because of this crossover between areas in our jurisdiction and areas not in our jurisdiction, run about 6 or 12 instances of this nature a year, either audit or investigation.

Mr. STEINBERG. You talk about D.M. & S. retaining independent individuals outside of their normal physician employees. Is it your opinion and the Chief Medical Director's opinion that qualified and experienced investigators, presumably M.D. investigators, would be available for ad hoc projects such as this?

Mr. REYNOLDS. They have been. In fact, one of the things ultimately done in Manhattan was to bring in such a team.

Mr. STEINBERG. Where did you obtain them?

Mr. REYNOLDS. D.M. & S. obtained them and I believe they were from nonaffiliated medical schools, as I recall. Georgetown was one, Boston—D.M. & S. actually brought them in. We can provide further details for the record on that.

Mr. STEINBERG. Would you, please?

[Subsequently, the Office of the Inspector General submitted the following information:]

Team of surgeons not affiliated with VA who reviewed the surgical program at VAMC New York, N.Y., following our investigation for the purpose of determining the adequacy of corrective actions:

Henry H. Balch, M.D., Clinical Professor of Surgery, Georgetown University, Director, Georgetown University Surgical Division, District of Columbia Hospital, Washington, D.C.

Robert J. Coffey, M.D., Professor, Department of Surgery, Georgetown University School of Medicine, Washington, D.C.

Claude E. Welch, M.D., Emeritus Professor, Harvard Medical School, Senior Surgeon, Massachusetts General Hospital, Boston, Mass.

Chairman CRANSTON. If a Medical Inspector Office were established within D. M. & S., do you believe that that Office should have sole jurisdiction—to the exclusion of the Inspector General—over issues relating to quality of care and competency of medical professionals?

Mr. REYNOLDS. If the issue were solely that, yes, sir, I do.

Chairman CRANSTON. Is the final decision yours to make in that regard in terms of jurisdiction?

Mr. REYNOLDS. I would have to say we have not worked that out. For those issues that have come to my office, yes, I would say we are in total control of that process. But there are obviously issues that arise every day within the Department of Medicine and Surgery, many of which we don't see today and I don't know we would necessarily see under this arrangement.

Mr. STEINBERG. What you are suggesting is that on matters that came to the Inspector General in the normal course, you would make a judgment whether to defer to the Medical Inspector's Office. If other matters were assigned to that office by the Chief Medical Director, that would be another matter, but you would retain jurisdiction for making the decision under the Inspector General Act for matters brought to your attention?

Mr. REYNOLDS. Yes, that is correct.

Chairman CRANSTON. If a Medical Inspector Office were established within D.M. & S., would you differentiate between quality of care and competency issues on the one hand, for which such an office would be responsible and fraud, abuse, and mismanagement issues on the other hand, for which the Inspector General's Office would continue to be solely responsible?

Mr. REYNOLDS. Very much so, yes.

Chairman CRANSTON. If such an office were established, what types of provisions would be made for consultation and coordination between the Inspector General's Office and the Medical Inspector's Office?

Mr. REYNOLDS. Our perception is that on a spectrum there are cases at one end that are clearly fraud, waste, abuse, et cetera, and clearly within our jurisdiction. On the other hand, there are pure quality of care and competency cases and clearly within the Medical Inspector's jurisdiction.

Trying to narrow the gray area in the middle and the overlap will have to be worked out by sitting down together and analyzing the case and the aspects of it and determining how we would go about carrying out the specific investigation. We will have to work that out on an ad hoc basis as cases arise.

Chairman CRANSTON. It seems to me that a possible alternative to this proposal would be to create a medical unit within the Inspector General's Office, staffed or headed by physicians and others with health care backgrounds which would be responsible for investigating issues relating to quality of care and the competency of medical professionals. What is your view on that sort of approach?

Mr. REYNOLDS. I see two problems with it. One, the volume of workload is not that great and we would have to have a large range of specialists in order to handle the types of problems that come up.

Second, there are some indications at least that you could not hire M.D.'s or very many of them who would want to concentrate their time on this sort of activity. Being able to find somebody to do this occasionally is one thing, but to have a permanent staff consisting of a wide range of professionals who work at this full time does not look very practical.

Chairman CRANSTON. Did you and the Chief Medical Director discuss such an alternative?

Mr. REYNOLDS. Yes, sir, we did. In fact, my original proposals to the then Chief Medical Director in effect said that, if you are not going to create a Medical Inspector, then I feel I will probably have to move forward to establish my own capability because we just can't live with the way things are today.

Chairman CRANSTON. If a medical unit were established within the Inspector General's Office, would you foresee any problems in recruiting competent medical professionals to serve on the staff?

Mr. REYNOLDS. Yes, sir. As I indicated, the best information I have been able to get is that it would be very difficult because you won't find many doctors interested in doing this sort of work as a full-time occupation.

Chairman CRANSTON. Has any consideration been given to obtaining the services of physician consultants under section 6(a)(7) of the Inspector General's Act to carry out investigations relating to medical issues?

Mr. REYNOLDS. Consideration was given to it up to a point but the best reading I could get on that was that we would have to do it under a retainment arrangement and my conversations with procurement people indicated that that would be a little unusual and perhaps not possible under procurement regulations, but that would be an option that could be explored further.

Mr. STEINBERG. Are you suggesting D.M. & S. might be able to make such arrangements more effectively than would your office in terms of workload and having people available when investigations need to be conducted?

Mr. REYNOLDS. In a sense, yes, because they have a range of specialists in-house already, plus they have access to a range of specialists through the affiliate institution program. In addition, they have further access to a range of specialists through the fellowship scholarship program. They have quite an access, if you will, to the medical community that we simply don't have.

Mr. STEINBERG. You could not use their access to the medical community through affiliated institutions and through the fellowship program to retain those individuals yourself as consultants or on some other basis?

Mr. REYNOLDS. We honestly did not look into that option and we possible could, yes, I had not thought of that.

Chairman CRANSTON. Would you intend to monitor the effectiveness and independence of the Medical Inspector Office in the D.M. & S.?

Mr. REYNOLDS. Yes, sir, I see that office coming under our audit jurisdiction or oversight the same as any other office or activity.

Mr. STEINBERG. Would that be a matter of primary focus for you, rather than just another matter in the agency that you would have to pay some attention to? We are concerned about public credibility with respect to this issue.

You yourself said that on any charges widely publicized you think the press and perhaps the public would be wary of D.M. & S. investigating itself and by that you mean using its own regular employees to investigate allegations. That being the case, the credibility of your operation is also brought into question in that regard and it would seem that you might have a great stake in assuring yourself that the independence of a Medical Inspector's Office were maintained, were reinforced, and made known to the public.

Mr. REYNOLDS. I think your point is well taken and I guess I could draw a parallel with our heavier oversight of the Department of Benefit compliance activity with schools. This is a function one might perceive as being a function of my office. However, it is a program line function, but we give it extra attention because of its relative importance to adequate maintenance of that system.

Mr. STEINBERG. Would you provide for the record, after the final agency decision is made on this matter, exactly what your plans would be, what resources you would devote to the monitoring of this office if it is established, and what your personal connection would be with that monitoring activity?

Mr. REYNOLDS. I will do so.

Mr. STEINBERG. Thank you.

Chairman CRANSTON. Would you please provide for the record an analysis of the advantages and disadvantages of each of the proposals I have discussed with you as well as any other proposals which were discussed between you and the Chief Medical Director and any others you think may be reasonable?

Mr. REYNOLDS. Yes, sir.

[Subsequently, the Office of the Inspector General submitted the following information:]

The primary options discussed for establishing a capability to investigate sensitive quality of medical care allegations are:

—Establish a separate division in the Office of Inspector General

—Establish a medical inspector, reporting to the Chief Medical Director.

It should be noted that most complaints relating to quality of care are made and satisfactorily resolved at the medical center level. Furthermore, the basic systems for monitoring and controlling the quality of care are established and operated within each medical center. We have audited these quality control systems. The systems are also reviewed periodically by the Joint Commission on Hospital Accreditation and by D.M. & S. reviews known as SERP reviews. The sensitive quality of care allegations to be addressed by one of these optional organizational arrangements are those that have been elevated by complaints to the Chief Medical Director, the Administrator, the Inspector General, the President, the Congress, the media or other individuals or organizations above the hospital level.

The substantive structure of the options is essentially the same. The medical inspector unit would be small in size, using VA and consultant medical specialists on an ad hoc basis to carry out most of the investigations. Such ad hoc assignments would provide specialists compatible with the nature of the issues raised in the allegations. A management analyst or someone with similar background would be assigned to the medical inspection unit to assist in designing/controlling the scope and procedural aspects of the inquiry. The results of such inquiries are to be objectively established and reported along with appropriate recommendations for necessary corrective action.

Following are the key issues that I believe should be considered in selecting between these options:

Independence.—The independence perceived by complainants and others will be greater if the Inspector General is responsible for investigation of serious and sensitive allegations about the quality of care. The real independence of such investigations being conducted by the Department of Medicine and Surgery can be enhanced by having the medical inspector report directly to the Chief Medical Director and close oversight by the Inspector General. The proposal being considered provides for both of these features—oversight to be accomplished as follows:

1. For those cases requiring joint efforts by my staff and the Medical Inspector, the Inspector General will have lead responsibility.

2. For cases referred to the Medical Inspector by the Inspector General, there will be pre-consultation on the proposed scope and resources to be used on the investigation. The investigative report will be reviewed by the Inspector General for adequacy and appropriateness of recommendations.

3. For cases which are undertaken by the Medical Inspector as the result of allegations received from sources other than through the Inspector General, the Inspector General will be advised of such allegations and provided a copy of reports resulting from their investigation.

It is anticipated that the actual depth of these oversight activities will vary. Intensity will be greatest when the allegations are most serious, effect multiple rather than single beneficiaries, or otherwise create a particularly sensitive situation. It is also anticipated that experience will produce refinements in the definitions of responsibilites of the Inspector General and the Medical Inspector which will permit us to target joint efforts and oversight into the most productive cases.

Access to medical expertise.—The medical inspection unit needs to be headed up by a very competent medical professional. The Department of Medicine and Surgery can pay a salary bonus to attract such an individual; the Inspector General cannot. The Department has an existing staff of physicians and consultants which can be readily accessed to provide the range of specialties to meet the varying situations. The Inspector General has readily accessed such resources with the assistance of the Department, but, at times, this has not proved to be a wholly satisfactory arrange-

ment due to problems of timeliness or quality. Hiring consultants for this sole purpose by the Inspector General will not be easy. By contrast, the Department hires consultants for a range of services of which assistance in pursuing quality of care allegations is one.

Efficient use of resources.—The number of quality of care cases of a serious or sensitive nature which have come to the attention of the Inspector General has been 6–12 per year. They do require a rather broad range of medical specialties, however. To apply several Inspector General positions, and additional funds for consulting contracts from the austere budget of the Inspector General will require diversion of resources from our major missions, assigned by the Inspector General Act of 1978, to promote economy, efficiency and effectiveness and prevent and detect fraud and abuse. By contrast, the Department of Medicine and Surgery has a legislative mandate to maintain quality of medical care in the medical programs of VA, and the resource impact is minute for the Department in relation to the total resources available.

Responsiveness of medical professionals.—Our experience indicates that medical professionals will more readily accept and cooperate with quality of medical care inquiries conducted under the auspices of a medical organization rather than an Inspector General organization.

I believe that the balancing of these considerations favors the establishment of responsibility for investigating serious and sensitive allegations of lapses in quality of care in the Department of Medicine and Surgery. By exercising control over the investigation of matters which come directly to or are referred to the attention of the Inspector General, I believe we can minimize problems of perceived independence.

Chairman CRANSTON. The close relationships which have developed between the VA and its affiliated medical schools have generally been very beneficial to the VA, to the medical schools, and to VA patients. Thus, the committee is concerned about complaints it has received regarding the manner in which Inspector General investigations are conducted at VA health care facilities and the effects of those investigations on patient care and on the VA's relationships with affiliated medical schools.

What special training is received by Inspector General investigators who are assigned to investigations at VA health-care facilities?

Mr. REYNOLDS. I would like to ask Mr. Rettew to answer that.

Mr. RETTEW. In the past, we have hired investigators with broad investigative experience. We have not gotten them normally through the VA but we have gotten them through other agencies such as the military. We don't have specific training in medical programs. We cover all elements of the VA and it simply is not practical to specifically train investigators in each element of it.

We do, however, provide, before we send them out on investigations, an opportunity for orientation at VA hospitals, VA regional offices, meetings with the Department people and normally we send each new investigator out on one or more investigations, an on-the-job training situation, if you will, with a senior investigator.

We also require them to keep abreast of all VA policies and regulations in all the departments.

Chairman CRANSTON. Do all Inspector General investigators receive this training or are certain investigators specifically assigned to investigations of VA health care facilities?

Mr. RETTEW. We have never been large enough to specialize, if you will, with our investigators. Whether we will be able to do this in the future with the increase in personnel that we have, I am not certain. But in the past, we have simply not had enough personnel to be able to specialize.

Chairman CRANSTON. Does your investigative staff include any physicians, health-care professionals or others with expertise in the health care field?

Mr. RETTEW. It does not.

Mr. REYNOLDS. Mr. Chairman, I might add that at least for the next year, we will have a physician available to us 1 or 2 days a week to assist us and perhaps to get a better understanding. He will be on my staff.

Chairman CRANSTON. Excuse me for a moment, Jon Steinberg will carry on.

Mr. STEINBERG [presiding]. You said those will be consultants?

Mr. REYNOLDS. One physician who will be working for us for a year, 1 or 2 days a week. He has been working and will continue to work with the HHS Inspector General as well.

Mr. STEINBERG. Would you or Mr. Rettew describe the steps taken by one of your investigators at the outset of an investigation? For example, does he inform the subject of an investigation of allegations against him or her?

Mr. RETTEW. At the outset of an investigation, of course, we first contact the facility director and advise him of the nature of the matter. The point at which the subject of an investigation is contacted depends very much on the specific allegations and the nature of the matter being investigated.

Normally at such time as we are satisfied that entering into discussion with the subject will not jeopardize the conduct of the investigation, we do contact him and tell him in general terms what the allegations are and that we will be back and have a further discussion with him to give him a full opportunity to respond to whatever information we have developed.

Mr. STEINBERG. Do you indicate to him that he is the subject of the investigation?

Mr. RETTEW. Yes.

Mr. STEINBERG. If that person happens to be a part-time VA, part-time affiliated medical school employee, does the investigator contact the medical school dean and inform the dean of the allegations?

Mr. RETTEW. Not routinely. We contact the director of our own VA facilities, although in specific cases, before we have made contact with some individuals active in the medical school, we have made contact with the deans but not routinely.

Mr. STEINBERG. Are you considering any policy modification in this regard?

Mr. REYNOLDS. I was going to add, we already have decided to make it a matter of routine for the future because we can almost anticipate a complaint if we don't.

Mr. STEINBERG. Will you go to the dean in those situations yourself?

Mr. REYNOLDS. Our investigator will go to the dean and the hospital director, basically with the same information to be conveyed to the dean that we currently convey to the hospital director.

Mr. RETTEW. I might add this depends on the nature of the investigation. There may be cases where we would have to conduct an investigation initially discreetly. Also, if the U.S. Attorney's

Office happened to be involved, we might not be able to go in and inform them of what was happening.

Mr. STEINBERG. Is a person under investigation afforded the right to counsel during questioning? That is, if the person requests to have counsel present, is that permitted?

Mr. RETTEW. Absolutely.

Mr. STEINBERG. Are all such targets of investigation advised at the outset of your interview of their right to have counsel present?

Mr. RETTEW. Not necessarily. If there appears to be a criminal matter involved, we very specifically advise him. If anyone wants an attorney to be present, we certainly will allow it.

Mr. STEINBERG. Is it a matter of that individual's own knowledge of their ability to exercise that kind of a right, rather than you informing them in each instance that they have that right?

Mr. RETTEW. Yes, again as I say, except for criminal matters, we do not take the positive step of advising them of the right.

Mr. STEINBERG. Mr. Reynolds, would you consider whether or not a policy modification with respect to that kind of advice being given to the subject at the outset of an interview might be consistent with conducting the investigation in an effective manner? I think there are conflicting considerations here and you might want to consider that for the office and report back to us.

Mr. REYNOLDS. OK. I was going to say very briefly I have spent a lot of time looking into this issue. I am not a lawyer by background but I have dealt with the Justice Department and in the last week and a half I have hired a new deputy who comes from the Department of Justice, Criminal Law Division, and we have looked at this matter at some length.

We have a VA manual section that establishes this right and probably the best solution will be to get this manual section out to the people, particularly the part-time people who ordinarily don't see the VA manual. There is a notion that warning people of their rights during an interview unnecessarily tends to chill the investigative process. The advice we are getting is that we should do this only in limited situations. In point of fact, we don't have to do it at all. The Miranda warning is speaking specifically to a custodial situation and we do not take people into custody. Our practices are consistent with the other Inspector General practices according to conversations I have had with them.

Mr. STEINBERG. Do other witnesses who are not identified as targets of the investigation have the same right to have counsel present if they wish?

Mr. RETTEW. They have the right but we don't specifically advise them. If they request it, we allow it.

Chairman CRANSTON [presiding]. Have there been any instances where a VA employee has refused to cooperate with an Inspector General investigation?

Mr. RETTEW. There have been a few. I cannot cite an example at this point.

Chairman CRANSTON. What types of disciplinary action, if any, have been taken against such employees?

Mr. RETTEW. Again, I can't recall a specific case, but there is provision for taking disciplinary action up to and including removal.

Mr. STEINBERG. Would you try to answer both of those questions for the record if you could without identifying individuals?

Mr. RETTEW. I'm sorry?

Mr. STEINBERG. Would you try to answer both of those questions for the record, both the question with respect to whether there have been instances where VA employees have refused to cooperate and what, if any, disciplinary actions have been taken in those cases?

Mr. RETTEW. There have been instances——

Chairman CRANSTON. What he asked is that you supply it for the record without giving the names of the individuals.

Mr. RETTEW. All right.

[Subsequently, the Office of the Inspector General submitted the following information:]

We are unable to recall any instance in which failure to cooperate in an investigation has, in itself, resulted in disciplinary action. There have been instances of initial failure on the part of employees to cooperate which have been resolved locally by arranging for counseling of the employees by field station directors or other management officials as appropriate. In recent times, this approach has resulted in obtaining the necessary cooperation, with one exception. In this case, the employee refused to discuss with the investigator allegations which had been made against him. Because of the possibility of prosecution, we did not press for disciplinary action based on this refusal to cooperate. In this instance, the Justice Department subsequently declined to prosecute. Disciplinary action was taken against the individual for specific, serious irregularities which were developed as the result of the investigation.

Chairman CRANSTON. The Inspector General Act of 1978 gives the Inspector General the authority to have access to all records, reports, audits, and other material which relate to programs and operations with respect to which the Inspector General has responsibility under the act.

I agree that this authority is necessary for the Inspector General's office to carry out its responsibilities successfully. However, it seems to me that problems would arise if the investigator seeks direct access to an individual's desk drawer or file cabinet or other areas in his or her office in which personal or confidential materials are kept.

Personal and professional sensitivities may perhaps be especially keen where the individual is a VA physician or a physician who works part time for the VA and part time for a medical school and his or her VA and medical school records or files are merged in one place.

Under what circumstances might one of your investigators seek access to or take control over an employee's desk or file cabinet or search through files or papers that are apparently not related to an investigation for papers that are relevant?

Mr. RETTEW. First of all, we would not attempt to take over anybody's desk. We do not go through desks, we do not examine desks, unless we have specific authorization of the individual whose desk it is and have him present with us.

Mr. STEINBERG. And he has the right to deny that authorization?

Mr. RETTEW. Yes. For file cabinets——

Mr. STEINBERG. Is there an instruction to your investigators to that effect?

Mr. RETTEW. Yes.

Mr. STEINBERG. Would you provide that for the record, please?

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Mr. RETTEW. Yes.

[Subsequently, the Office of the Inspector General submitted the following information:]

The following is an excerpt from the VA Policy and Procedure Guide for Special Investigators:

Consent of an individual to search his desk, locker, automobile or quarters (on or off the station) must be in writing signed by him and witnessed and must clearly show that it is given voluntarily and that he understands and waives his constitutional protections against unreasonable search and seizure. A witness should be present at a search and a record made and witnessed of the contents of the area searched and any material removed.

Mr. STEINBERG. Please proceed.

Mr. RETTEW. On the question of files, I would agree that it may be difficult at times with part-time physicians with offices at the VA to differentiate between university files and VA files. We do feel that we have access to records maintained at the VA hospital in a VA file cabinet and I believe complaints may have risen out of specific case, Denver I presume, and we did access a file cabinet in the physician's office.

It was a VA file cabinet and the materials in that cabinet related to some non-VA activities but all of the correspondence initiated by the physician was on VA stationery and signed by him in his official position with the VA and we felt our access to that information was perfectly appropriate.

Chairman CRANSTON. If a physician is employed by the VA and an affiliated medical school and keeps files at the VA facility relating to his or her medical school activities, do you believe that those files are subject to inspection by an Inspector General by virtue of being on VA property?

Mr. RETTEW. Not really. What we want to see is VA records and we certainly have no desire to review records of a physician as they relate to his medical school activity.

Mr. REYNOLDS. Mr. Chairman, I would like to put a qualification on that. Sometimes we get allegations that a physician is using his VA office and VA operation to carry on a private practice and we get into the problem of how we are going to explore that if we don't look at the activities of that office and what the secretary is doing and what files are being maintained and what files are created and so forth.

There are situations in which it seems to me we cannot deal with the allegation unless we access the available files.

Chairman CRANSTON. Is the physician given the opportunity to separate files relating to his or her non-VA activities prior to the inspection by the investigator?

Mr. RETTEW. We have not offered this, no.

Mr. STEINBERG. Do you think that would be inconsistent with carrying out a thorough investigation?

Mr. RETTEW. To a degree, it would. If he wants to separate these files in our presence, fine. Otherwise if he is aware of what we are concerned with, this gives him the opportunity to cull out not only non-VA material but perhaps pertinent materials.

Mr. STEINBERG. If an individual requested the opportunity to make such a separation, would you permit him to do that in your presence?

Mr. RETTEW. If he provided us with a good reason for doing so, yes.

Chairman CRANSTON. Does the investigator ask an employee for permission to inspect his or her files?

Mr. RETTEW. Yes, they do. They don't just go in and start rummaging through cabinets. We do go to the employee concerned.

Mr. STEINBERG. Is there an instruction on that issue as well?

Mr. RETTEW. I don't know how it is specifically spelled out in our policy but I will get back to you on that.

Mr. STEINBERG. Please provide that for the record.

Mr. RETTEW. Yes.

[Subsequently, the Office of the Inspector General submitted the following information:]

VA Regulations 452, Cooperation of All Officials on Investigation, and VA Policy Manual, MP 1, Part I, Chapter 2, Para. 204.05, Cooperation of VA Personnel During Investigations, require the making available of all records to the investigator. Section 6(a) of the Inspector General Act provides for access to all records relating to programs and operations in which the IG has interest. The actual mechanics for access are not spelled out.

Chairman CRANSTON. Let's get to the Palo Alto situation. In requesting that you undertake the investigation at the Palo Alto VA Medical Center, I stated that the serious allegations about the medical center that had been raised in the press deserved a full and complete investigation.

As you know, I asked the General Accounting Office to report to the Committee on the thoroughness and impartiality of your investigation at Palo Alto and stated specifically my intention to raise questions about that investigation at this hearing.

The GAO states that because your Palo Alto report did not reach conclusions for many allegations, the GAO attempted to do so based on the report and supporting documentation. Thus in the GAO's judgment, 8 of the 37 allegations addressed by you were sustained, 17 were not sustained and 12 were unresolved.

Do you concur in the GAO's scorekeeping on your report?

Mr. RETTEW. I have not made a specific count, Mr. Chairman, but I prepared a comment on Palo Alto and the adequacy of our investigation.

Mr. STEINBERG. We will have an opportunity to cover that as we go through the questions but would you, for the record, confer with the GAO with respect to their assessment and then provide for the record, assuming that their count of 37 allegations are concurred in, where your judgment differs and where your judgment is the same as to each of the allegations?

Mr. RETTEW. Absolutely.

[Subsequently, the Office of the Inspector General submitted the following information:]

As a result of several meetings with GAO, they have agreed to make limited changes with respect to allegations 8, 9, and 10, with which changes we now agree. However, we and GAO have not reached agreement on the following issues:

Allegation No. 3.—Palo Alto police refuse to become involved in theft, accident, or vandalism cases on VA grounds.

GAO had concluded that this allegation was not sustained in part. We disagree with the "in part" since in only one instance was specific evidence presented which disclosed that the Palo Alto police did not respond promptly to calls received from the VAMC Palo Alto.

Allegation No. 4.—California Congressmen were provided substantial documentation of criminal activities within the VA.

We and GAO are in agreement that it is unclear as to what the allegation is. GAO found it to be unresolved, assumed that the allegation related to increased criminal activities, and believed we did not develop sufficient evidence on the matter. In light of GAO's views we have developed the following additional information:

We have made an analysis of the AMIS reports submitted by the VAMC Palo Alto for fiscal years 1977, 1978, 1979, and through May of fiscal year 1980, which had been previously provided to GAO with a projection for the balance of fiscal year 1980. This analysis, a copy of which is attached, shows that between fiscal year 1978 and 1979 there was a decrease in four particular categories and an increase in five categories with an overall 2 percent decrease in total offenses. Comparing the projected figures for fiscal year 1980 with the actual figures for fiscal year 1979 we find a decrease in all categories except total traffic violations, and an overall 3 percent decrease in total offenses. James G. Fasone, Chief Security Division, DM&S, advised that a drastic percentage increase in crimes, assaults, and disturbances are viewed by DM&S program management officials as a result of increased local attention to recordkeeping and not the result of a significant increase in occurrences. The FBI Uniform Crime Reports reflect an approximate 10 percent decrease in crimes for the cities of Palo Alto and Menlo Park in 1978 over 1977 whereas nationwide there was an approximate increase of 15 percent. Also VAMC Palo Alto records show that from about January 1978 until October 1979, Mize had the responsibility of preparing the AMIS reports. Police Chief Hoban of the VAMC Palo Alto, at our request recently reviewed the records regarding "Total Disturbances" for fiscal years 1977, 1978, and 1979, and determined that the figure of 248 for fiscal year 1977 should have been 208, the figure of 805 for fiscal year 1978 should have been 312, and the figure of 842 for fiscal year 1979 should have been 357. Chief Hoban stated that these differences are caused by a different interpretation of what constitutes a disturbance. Hoban also reported that between 200 and 300 additional parking spaces were made available in fiscal year 1978 which accounted in part for the decrease in "Total Traffic Violations" for fiscal years 1978 and 1979. Hoban also reported that the increase in "Total Nontraffic Arrests" in fiscal years 1978 and 1979 was because of a concerted effort to control the purchasing of liquor and bringing it back on the medical center grounds by Menlo Park patients. It is our intention to selectively verify the above figures.

Allegation No. 6.—Traffic tickets, particularly for doctors, are routinely dismissed.

GAO concluded that this allegation was sustained in part. We agree with this conclusion and GAO's comments except the comment that "the OIG investigator only sampled 11 tickets for analysis". The investigator reviewed approximately 3,000 tickets. This review disclosed that it was impossible to determine whether the persons to whom the tickets had been issued were visitors, patients, construction workers, employees, or physicians. We will make recommendations relating to ticket cancellation policies to the Department of Medicine and Surgery.

Allegation No. 13.—The VA Police Chief converted Government property to private use.

GAO concluded that this allegation was sustained. Although the Police Chief admittedly inappropriately borrowed a stepladder over the weekend to use in painting his house we feel a conclusion that he "converted" Government property to his own use dramatically overstates the incident. We would note that there was no evidence that the Police Chief stole other specific property which he was alleged to have stolen.

Allegation No. 17.—There was a $7 million coverup in the supply section books.

GAO concluded that this allegation was unresolved. As shown in our report the police officer who made this allegation failed to produce the witness who presumably had knowledge of the alleged coverup. Other contacts made by our investigators and the FBI failed to disclose any knowledge of a problem in the supply service. An audit of the VAMC Palo Alto by the Office of Audit completed on 4-13-79 gave no indication of any coverup, although it did disclose that improvements were needed in the controls over taking inventories for nonexpendable equipment, that excess equipment was stored, that controls over the annual warehouse inventory was not adequate, and that the value of posted stock inventory as of January 31, 1979 was $501,502. Therefore, it appears very unlikely there could have been a $7 million coverup in the supply section books. However, we are making a further attempt to induce the officer to produce the witness, as discussed subsequently in this hearing record.

Allegation No. 20.—The VA Police Chief told the police officer who made many of the allegations that his career was ended and reprisals were being taken against the officer.

GAO concluded that this allegation was unresolved. We did not conduct an investigation of this matter because of our understanding of the involvement of the Office of Special Counsel. At our request, the Office of Special Counsel has agreed to look into the possibility that the officer was subject to prohibited personnel practices.

Allegations No. 25, No. 26, and No. 27.—VA shop employees refinished an old typewriter stand for private sale. The Police Chief gave his son a VAMC police document carrier. The Police Chief removed $20 from a recovered wallet.

GAO concluded that these allegations were unresolved. The individuals who made these allegations were unable to provide evidence or leads to follow to prove the allegations. The allegations were referred to the Federal Bureau of Investigation who presented the charges to the United States Attorney who declined prosecution. We agree with GAO that no further investigation is warranted but do not agree with GAO's characterization of these allegations as being unresolved. They are not sustained.

Allegations No. 31 and No. 32.—Poor maintenance and utilization of Bio Medical equipment existed. Work orders for the repair of medical equipment are delinquent.

GAO concluded that these two allegations are unresolved. Neither of the allegations had a bearing on the matter under investigation and was not investigated by us.

ANALYSIS OF UNITS REPORTS

Category	FY 1977	FY 1978	% INCREASE OR DECREASE	FY 1979	% INCREASE OR DECREASE	FY 1980 THRU MAY	PROJECTED FY 1980	INCREASE OR DECREASE
Total Forced Entries	2	12	+500	17	+ 41	4	6	- 68
* Total Thefts	167	180	+ 7	218	+ 21	127	190	+ 11
Total Robberies	1	3	+200	4	+ 33	1	2	-100
Total Traffic Violations	2295	1661	- 28	1429	- 12	1363	**** 2044	+ 40
Total Other Offenses	142	160	+ 12	159	-	51	77	- 51
Total Assaults	19	61	+115	28	- 31	16	24	- 52
** Total Disturbances	258	805	+212	** 842	+ 4	248	372	- 44
Manslaughter	0	1	+100	0	-100	0	0	0
Total Vandalism	17	49	+188	49	same	13	20	- 60
Total Nontraffic Arrests ***	31	78	+151	*** 136	+ 80	32	48	- 40
Total Acts Committed	2932	2968	+ 1	2882	- 2	1855	2783	- 3

* The net increase of 38 consisted of the following:

Theft of Personal Property 50 + above	+ 1
Less than 50	+22
Government Property 50 + above	+16
Less than 50	+ 4
Private Vehicles	+ 1
Attempted theft	+ 1
	45
Narcotics	- 7
	+38

** The net increase of 37 consisted of the following:

Outsiders	-35
Employee - Patients	+75
Bomb Threats	- 4
Threat to employees	+ 1
	+37

*** The net increase of 50 consisted of the following:

Physical Arrests	+19
Arrests thru U.S. Dist. Court	+31
Violation Notices	+50

**** The net increase of 615 consisted of the following:

Courtesy Parking Violations	- 44
Moving Violations	- 31
District Court Violation Notices	+710
	+615

Chairman CRANSTON. The GAO also took the position that three unresolved allegations warrant further investigation by you; namely, the increasing crime rate at Palo Alto, an alleged $7 million coverup in records of the medical center's supply section and the harassment of a VA police officer. Do you agree that these three allegations warrant further investigation and that in each case your office should do it?

Mr. RETTEW. No, sir, I do not agree. I would want to review one of the points and that is the crime rate, although I do feel we covered this.

On the question of the $7 million shortage, this allegation came to us thirdhand through a police officer who claimed that another police officer who was also a principal complainant in this matter had gotten the information through a girl friend of his. We made repeated efforts through the second officer to make that individual available to provide us with information and he failed to do so.

We did make further inquiry, we had discussions with people in a position to be aware of difficulties of that magnitude and we came up with nothing.

The FBI also concerned itself with this matter and I don't know the full extent of their inquiry but they found no basis to pursue it further. So I do not agree that that should be pursued further.

Mr. STEINBERG. As far as you are aware, neither you nor the FBI actually at any point interviewed the alleged source of the allegation?

Mr. RETTEW. That's right.

Mr. STEINBERG. When you said there was an attempt to make that person available, was it not possible for you to determine that person's name?

Mr. RETTEW. I don't know if our investigator had her name or not. The police officer was supposed to have made her available to us and simply failed to do so. I might point out that there had been a prior audit in supply and I don't recall exactly when, not too distant past, that showed nothing

Mr. STEINBERG. Given the degree of notoriety—and the chairman is going to raise this in the course of these questions—that attached to that particular allegation in the press, don't you feel it would be helpful if a special effort were made to contact that individual in order to lay this allegation to rest if indeed you believe it is not able to be substantiated?

Mr. RETTEW. We have made attempts to contact that individual.

Chairman CRANSTON. How much attempt was made?

Mr. RETTEW. I can't answer that fully.

Mr. REYNOLDS. If I remember from reading a report on this point, there were rather frequent contacts back to the police officer and the police officer did not give us the individual's name but instead would arrange for that individual to get in touch with us. I might add——

Mr. STEINBERG. Does the police officer have the right to withhold that name from you?

Mr. REYNOLDS. I guess we don't know quite how to get it out of him. But I think the point that bothered me about the——

Mr. STEINBERG. Let me pursue that for a minute. The police officer is a VA employee and made certain serious allegations and made them to the press?

Mr. REYNOLDS. Yes.

Mr. STEINBERG. When requested to tell you the basis for that allegation, he said somebody told me that. You do not know whether your investigator pressed the police officer for the name of that person?

Mr. REYNOLDS. Offhand I don't know, we would have to check the file.

Mr. STEINBERG. It is understandable, perhaps, that you would prefer that person to come forward. But, once it became clear that that person did not come forward and was not coming forward, despite what you suggest were repeated recontacts with the police officer, it seems to me—given again the magnitude of publicity involved with all of these allegations, including this one—that it was incumbent on you at that point to secure the name from that police officer.

It seems to me the police officer is in a position at that point either to withdraw the allegation, provide the name, or suffer whatever disciplinary consequences should be appropriate if he would not provide the name.

Mr. REYNOLDS. I think though if you look at it in the context of the fact that that police officer and a couple of others made a whole string of allegations, almost all of which were either not valid or were grossly distorted——

Mr. STEINBERG. In many instances, you went to the source of those allegations and interviewed the source and the source did not sustain the allegation. We are talking about this one situation which allegedly involves a substantial amount of U.S. Government property and money where you were not able to get to the source.

I don't think we have to belabor this at length. It would be appreciated if you would consider whether it is not appropriate for you to make a recontact to see if you can pin this down further.

Mr. REYNOLDS. We will do so.

Mr. STEINBERG. Thank you.

[Subsequently, the Office of the Inspector General submitted the following information:]

On June 26, 1980, our investigator reinterviewed Mize, who again refused to identify his source of information. He maintained this position even when advised that under VA regulations he could be subject to disciplinary action for refusal to cooperate in an investigation. It is of particular concern to us that an individual employed as a police officer would refuse to provide information that he claims to have regarding criminal activity.

A female employee of Supply Service was also interviewed, who we believed might be the source. While she acknowledged having had conversations with Mize and about Supply Service activities, and having known him since 1975 when they were neighbors, she denied having knowledge of any coverup or possible wrongdoings by anyone in the Supply Service.

If a significant coverup in Supply were uncovered, it would be highly unlikely unless it were by falsification of records, theft, concealment or collusion. Such activities would involve federal criminal violations, if such allegations were sustained. Therefore, I have requested the assistance of the United States Attorney, San Francisco, in finding the source of the allegations.

Chairman CRANSTON. The GAO also asserts that you should have pursued certain allegations that you did not address in your investigation. These include allegations of reprisals and threats against

VA police officers making allegations, inadequate law enforcement support from Federal agencies, VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities and VA police officers being assigned nonsecurity duties.

Do you agree that you should pursue those allegations?

Mr. REYNOLDS. Let me speak to the harassment issue and I will ask Mr. Rettew to speak to the balance. On the harassment issue, several police officers had complained to special counsel on the basis of prohibited personnel practices. We turned over the material we gathered with respect to harassment to the Office of Special Counsel and we did not feel we should run an investigation per se on this subject which was already within the jurisdiction of special counsel.

Mr. STEINBERG. Do they concur with you that this is a matter for them to handle?

Mr. REYNOLDS. I have not had a response from them.

Mr. STEINBERG. Would you expedite that matter and report to the committee?

Mr. REYNOLDS. I will do so.

[Subsequently, the Office of the Inspector General submitted the following information:]

We have provided a copy of our report to the Office of Special Counsel and we recently met with the Acting Special Counsel who agreed that her office would look into the possibility that the officers had been subject to prohibited personnel practices. Her office will also address the question we have posed as to whether disciplinary action can be considered where our investigation indicates that whistleblowing activities were made with willful disregard for the truth or falsity of the allegations—an exception provided in section 7(c) of the Inspector General Act.

Mr. STEINBERG. Mr. Rettew, do you want to respond to the other three? Let me repeat those for you. Those were inadequate law enforcement support from Federal agencies, VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities, and VA police officers being assigned nonsecurity duties.

Mr. RETTEW. On the first one, I remember the complaint as being a complaint of—I may be wrong on this, a complaint of failure of local law enforcement people to provide support. I think this was very thoroughly gone into and I would have to re-review the matter on the basis of Federal——

Mr. STEINBERG. I think there were allegations that both the FBI and DEA did not pursue allegations strenuously.

Mr. RETTEW. You mean in connection with this matter?

Mr. STEINBERG. I believe in connection with suspected drug traffic at the center.

Mr. RETTEW. I think—I am not sure——

Mr. STEINBERG. Why don't you check that for the record?

Mr. RETTEW. I will, but I'm not sure we are in a position to know the full extent of their inquiry into this matter. They did cooperate with us and they were aware of whatever we were aware of, but I will try to find out.

Mr. STEINBERG. All right.

Mr. RETTEW. I am not sure what they mean on the failure to pursue legal action against employees and patients suspected of being involved in criminal activities. We did pursue the matter of

failure on the part of the station to properly pursue citations given violators on the station.

If they are talking about the extent or severity of actions that can be taken, we are limited in title 38 to a $50 fine, although I understand this is under review at this point.

Mr. STEINBERG. Would you discuss that with the GAO specifically and report back to us so that you are both talking about the same instances? The last was VA police officers being assigned nonsecurity duties.

Mr. RETTEW. I remember some of this but not that much and I would also like to pursue that and see specifically what they have in mind on that.

Mr. STEINBERG. When you report back to us, please indicate if you can, any followup action on any of those items?

Mr. RETTEW. Yes.

[Subsequently, the Office of the Inspector General submitted the following information:]

A GAO supervisory auditor advised that with respect to "inadequate law enforcement support from federal agencies", our report did not address the issue whether the support received from the Federal Bureau of Investigation and the Drug Enforcement Agency was adequate. He stated there had been some allegations by police officers that the FBI never came to the hospital and that they received no cooperation from DEA. He further advised that with respect to "VA's failure to pursue legal actions against employees and patients suspected of being involved in criminal activities", GAO was referring to allegations in the newspaper that no administrative action was being taken by the station against employees and patients who were involved in criminal activities such as assaults, possessions of drugs or alcohol, etc. He further advised with respect to "VA police officers being assigned nonsecurity duties", there was some information which indicated that police officers were being assigned duties such as chauffering patients and performing other nonsecurity duties.

GAO said that they will be advising the Committee that GAO does not believe there is any necessity for the VA to pursue these matters further because GAO will be looking into all these areas during its inquiry of police activities at various VA installations.

With respect to inadequate law enforcement support from Federal agencies neither officer who made these allegations could furnish instances when Federal law enforcement agencies failed to respond when asked to do so.

With respect to VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities, no specific information, other than set forth in our report, was furnished by anyone, that patients or employees were involved in assaults or possession of liquor or drugs, and therefore, there was no way of determining whether the hospital may have taken appropriate action against individuals involved in such activities.

With respect to police officers being assigned nonsecurity duties the hospital director has the authority to determine the manner in which security personnel will be used including the transportation of belligerent patients, checking doors, and windows and burning lights all of which are considered appropriate duties for police officers.

Chairman CRANSTON. It seems to me that the GAO's position that your investigation was incomplete in certain major respects raises a serious concern in terms of the credibility of your report with the community. The allegations involved were among the most widely publicized in the community and I had received several complaints with respect to those allegations.

Do you agree that the credibility of your report in the community concerned is important in determining the adequacy of the investigative effort and thus, is a strong basis for pursuing certain major issues further?

Mr. REYNOLDS. I agree its credibility is quite important. I guess the problem is I don't agree with some of GAO's criticisms.

Mr. STEINBERG. It would be helpful—after you have reviewed this and talked to GAO directly—if you would issue to the community and all others to whom your initial report was made whatever supplementary statement you wish to make in response to the GAO. That would indicate that the issue has been dealt with to your satisfaction.

Mr. REYNOLDS. Be glad to.

Chairman CRANSTON. The GAO also expressed the view that your Palo Alto report should have disclosed the findings and conclusions resulting from a contemporaneous Drug Enforcement Administration investigation into illegal drug use at the VA hospital.

According to the GAO, the DEA "was unable to conclude that any significant or widespread drug activity existed at Palo Alto primarily because the VA police officers who had made the allegations could not . . . substantiate their allegations."

Do you agree with the GAO on this?

Mr. RETTEW. I don't know if it would be proper for us to include as part of our report another agency's investigation, DEA's investigation. They worked closely with our investigator and assured him that their inquiry found no basis to pursue the matter further.

Mr. STEINBERG. Do you agree with GAO's conclusion—their summary of what the DEA did find?

Mr. RETTEW. Yes.

Chairman CRANSTON. When do you intend to publish your recommendations based on this investigation?

Mr. REYNOLDS. This would basically await the response from the Office of Special Counsel because I have a different problem with what went on out there. Under the Inspector General Act of 1978, allegations which are made willfully or without adequate regard for the facts subject the individual making such allegations to disciplinary action.

I think there might be a basis for such disciplinary action in these cases, but meantime the special counsel has an investigation going looking into the question of whether or not improper harassment and disciplinary action has been taken on these individuals.

We have got to get together and the Civil Service Reform Act apparently does not have a similar provision to what the IG Act has with respect to willful disregard of the facts in making allegations.

Chairman CRANSTON. How much did the Palo Alto investigation cost, both in terms of money and staff resources?

Mr. RETTEW. Approximately $25,000, not taking into consideration whatever expenses were incurred by GAO in their review.

Chairman CRANSTON. From your final report, one could infer that you believe that most of the allegations raised were groundless. Do you believe that the individuals who raised those allegations believed them to be true when they first raised them?

Mr. RETTEW. I don't know. I don't know the purpose in raising them at the time they did. The Inspector General and Members of Congress received earlier letters from these police officers asking for intervention in their behalf when they raised purely policy matters. Certainly, if they consider these things as serious as they

say they do, they should have brought them up at that time rather than bringing them up at a later date in order to get us into the act.

Chairman CRANSTON. Are you aware of any instances of harassment of the police officers who raised these allegations?

Mr. RETTEW. Our investigator was told by one of the officers that he was being reassigned from the duties that he had been performing and that he regarded it as harassment. The officer also told him that he had made a complaint to the Merit System Protection Board and therefore we stayed out of it. We do have some questions as to whether he was harassed, yes.

Chairman CRANSTON. At your confirmation hearing, Mr. Reynolds, I provided you with seven challenges and indicated that the committee would evaluate your performance and the performance of the Inspector General's Office against those challenges. You accepted those challenges.

The first challenge was to reduce the total outstanding VA overpayments by 50 percent and to provide the committee with a plan showing how the remaining problem would be resolved.

On May 5, 1980, I received a report from you detailing the IG Office's accomplishments in relation to each of those challenges. That letter indicated that as of March 31, 1979, VA accounts receivable subject to further collection action totaled $411.8 million and that as of March 31, 1980, the total was $393.2 million. Total accounts receivable increased from $577 million as of March 31, 1979 to $620.4 million as of March 31, 1980, that is from 1979 to 1980.

That is a far cry from the 50-percent reduction contained in the challenge and I want to explore the steps you have taken and recommended in the accounts receivable area. As your May 5 report shows, this is really a two-part problem; one part concerns preventing overpayments from occurring and the other part, effective collection actions.

In your May 5 transmittal letter, you stated that corrective actions available to the VA have potential impacts measurable in no more than ones or tens of millions of dollars rather than the hundreds of millions needed in order to reduce accounts receivable by 50 percent. Are there any ways that could be used to achieve reductions in the hundreds of millions?

Mr. REYNOLDS. Yes, sir. I think the major way would be to use income tax offset. That is, offset of debts owed the Government against income tax returns. Studies indicate that for the size of the accounts we have on the average, a 50 percent or better success rate would be achieved in 2 tax years. That is, one of the fastest ways I know to do it and studies indicate that legal authorities exist to do this.

Mr. STEINBERG. Have you made it a recommendation that that be pursued?

Mr. REYNOLDS. In the sense that my semiannual report comes to the Congress, this has been a repeated recommendation in my semiannual report. It's been a recommendation of the Veterans' Administration to OMB, it has been a recommendation of the Veterans' Administration—this included my input to it—to the President's Debt Collection Task Force.

Mr. STEINBERG.. It is a matter the Treasury Department has grave concerns about.

Mr. REYNOLDS. That is correct and the Debt Collection Task Force in fact raised some questions about reliability of the accounting records. In other words, are the accounts receivable records reliable enough to have this be a fair and equitable method? The answer for VA, at least in the centralized educational accounts receivable which is 85 percent of the accounts receivable and about $400 million, and we did a study of that and found 94 percent reliability, 3 percent understated the amount of the debt and 3 percent overstated the amount of the debt.

To the extent there is any reliability problem from the standpoint of unfairness to the taxpayer, it would be in that latter 3-percent category.

Chairman CRANSTON. Currently the VA obtains address information on individuals indebted to the VA from the Internal Revenue Service for the purpose of sending out collection letters. However, legal action by the Department of Justice against individuals who have failed to respond to those letters is precluded because locator information obtained from IRS cannot be redisclosed to obtain credit reports which are required by regulations issued by the General Accounting Office and the Justice Department. I understand that a proposal has been pending in OMB since February 1979 to permit such redisclosure.

Has OMB given any indication as to when it will make a final decision on this proposal?

Mr. REYNOLDS. My understanding is that proposals of that nature and proposals with respect to tax offset will not be addressed until the task force—the President's Management Improvement Program Task Force on Debt Management—has finished its work which is scheduled for sometime this July or August.

Chairman CRANSTON. Are you aware of any objections OMB has to this proposal?

Mr. REYNOLDS. No, sir, I am not.

Chairman CRANSTON. Provisions of H.R. 5288, the proposed GI Bill Amendments Act of 1980, as passed by the Senate on January 24, would permit the disclosure of information to consumer reporting agencies in order to obtain credit information. Would the authority to redisclose information obtained from IRS be likely to produce substantially more recoveries than that legislation?

Mr. REYNOLDS. I believe two points are important here. My understanding is that the locator information service from the credit bureaus will probably cost in the range of $2.50. The current charge from the Internal Revenue Service is around 10 cents. You are looking at a cost factor.

The option—I don't know how far the credit bureaus will take you. Within Government, the perception is that the IRS records represent the best locator service that exists in Government. I don't know how it would compare with the credit bureau structure, however.

Chairman CRANSTON. A January 15, 1980, GAO report entitled "Unresolved Issues Impede Federal Debt Collection Efforts—A Status Report" states that GAO is considering recommending that

Congress authorize involuntary salary offset of debts owed to the Federal Government by its employees.

Is such a legislative proposal being actively considered by the executive branch?

Mr. REYNOLDS. I am not aware of any—I don't know the answer to that question.

Chairman CRANSTON. The Federal claims collection standards issued jointly by GAO and the Department of Justice require Federal agencies to charge interest on delinquent debts. However, at an August 2, 1979, hearing before this committee on VA debt collection efforts, the VA general counsel indicated that the administrative burdens that would be placed on the VA in computing interest might outweigh the benefits of charging interest on delinquent debts. What is your view?

Mr. REYNOLDS. I haven't seen any numbers behind that statement. The general view is that if we are going to be successful in pursuing debt collection, I think we need to go about it the way industry goes about it as much as possible

I can't believe that when industry charges interest that they don't find it cost beneficial to do so. It's hard to rationalize that for some reason the Government would not find it cost beneficial to charge interest when industry does.

Mr. STEINBERG. Would you look into that more closely and report back to us for the record as to whether you believe it would be cost effective?

[Subsequently, the Office of the Inspector General submitted the following information:]

There are no cost/benefit studies available for charging interest on outstanding debts due the Veterans' Administration. It was noted in the Report of the House Committee on Veterans' Affairs to accompany H.R. 7394, that the Congressional Budget Office (CBO) estimated that more than $50 million could be saved in fiscal year 1981 should the provisions for assessing interest and administrative costs be enacted. The CBO report to the Committee does not, however, show any associated costs. Nor has VA yet established such a cost estimate.

The determination of estimated costs is complicated because it may be impossible to segregate the cost impact of this from other initiatives which are also designed to stimulate collections. These include legal action to effect collection, referral of debtors to collection agencies, and more aggressive collection efforts prior to taking legal or credit impact steps. Further, it appears that the existing centralized accounts receivable system will not support these added activities and the need to bring other accounts receivable into the centralized system in order to process these accounts under the same procedures and authorities. It is not clear at this time when or even if the cost side of the equation can be established in a manner that isolates only on interest.

However, as indicated in my testimony, the common market place practice of charging interest for debts establishes the strong premise that this practice is cost beneficial, subject to added costs the Government incurs because of more elaborate due process procedures.

Chairman CRANSTON. Does the VA have clear authority to charge interest?

Mr. REYNOLDS. There have been legal opinions, as I recall, on this from GAO and from Treasury, I think. And my understanding is that legislation that has passed both the House and Senate and subject to joint conference would clearly establish that authority.

Mr. STEINBERG. I believe the legislation is on the House side only at this point.

[Subsequently, the Office of the Inspector General submitted the following information:]

Effective April 30, 1979, the Federal Claims Collections Standards (4 CFR 101-105) jointly promulgated by the General Accounting Office and the Department of Justice, were revised to require in § 102.11 that:

"In the absence of a different rule prescribed by statute, contract, or regulation, interest should be charged on delinquent debts and debts paid in installments in conformity with the Treasury Fiscal Requirements Manual. * * *"

In a letter dated January 29, 1980, submitted to the Comptroller General of the United States, the VA's General Counsel raised a number of questions concerning the authority of the VA to charge interest on delinquent debts arising out of direct benefit or entitlement programs. A Comptroller General decision B-197679 dated March 31, 1980 states that "the VA has the authority to charge interest on debts arising from benefit programs."

Chairman CRANSTON. Regarding defaults on VA education loans, the committee was greatly concerned by a March 6, 1980, report it received from the Administrator which indicated that the education loan default rate had again increased from 36.1 percent in fiscal year 1978 to 65.6 percent in fiscal year 1979. Would you explain the reason for this increase?

Mr. REYNOLDS. We have just finished a review of the debt collection program on the direct loan program. I would have to say that there is no effective, truly effective collection activity going on in that area. We find slowness in following up and sending letters, we find a lack of personal contact.

If the people paid us, that's fine, but what exists there is simply not effective today and we will make recommendations to strengthen that process. I think we can get the rate down some but I don't see a dramatic change.

Chairman CRANSTON. When will you make those recommendations?

Mr. REYNOLDS. Within a month.

Chairman CRANSTON. Senator Stafford, do you have any questions?

Senator STAFFORD. Mr. Chairman, I do not at this point, but I have an opening statement I would ask unanimous consent that it be placed in the committee record immediately after your own opening statement. Due to the unusual evening we have been through, I have been diverted to other activities which explains why I was not able to be here sooner.

Chairman CRANSTON. Thank you very much, glad you're here. Do you have any suggestions for lowering the default rate on education loans?

Mr. REYNOLDS. There can be more aggressive collection action which should reduce that rate some. But if we find the same general pattern that we have found in our overpayments, the VA is not going to come down very much on that rate in my judgment in any near-term period. Again, the potential for referring these for offset against tax refund is one of the clear options.

At this point, these cases have not been targeted for referral, either to our General Counsel for civil action or Justice for civil action, depending on the dollar value and that is something obviously that can be done.

Chairman CRANSTON. What improvements can we expect to see in the default rate for fiscal year 1980?

Mr. REYNOLDS. I am afraid that unless something is done awfully fast, you won't see an improvement, you will see a higher rate by the end of this fiscal year than you are seeing right now.

Mr. STEINBERG. Even with the new regulations that have gone into effect?

Mr. REYNOLDS. I took a brief look at this and even with the new regulations we are beginning to see accounts showing up now that postdate those regulations. I don't see any indication of things getting better as a result of the new regulations. Let me qualify that.

There were two major changes. One was to improve obtaining address information which had been very poorly done.

The other was to change and move us away from a lender of last resort on 100 percent of the loans. As I said, loans made after these changes are now finding their way into the default accounts and they don't show a pattern different from what was there before as far as I can see.

Mr. STEINBERG. I don't want to comment on the House legislation, but, if H.R. 5288, as passed by the Senate were enacted, a default would be able to be entered in an individual's credit rating. Do you think that would have a significant effect on collections after default?

Mr. REYNOLDS. I would like to hope so, that people would react to that and pay their debts. GAO pointed out in one of their studies that very often people were paying their private debts because of the knowledge that they could be affected on their credit report and there was no similar penalty existing then or today for that matter with respect to Government debts. Therefore, Government debts were unpaid or at least got the last crack at the paycheck, if you will.

Mr. STEINBERG. Do you concur with GAO in that analysis?

Mr. REYNOLDS. Yes, sir.

Chairman CRANSTON. In general, do you believe that budgetary and staffing constraints are interfering substantially with the VA's ability to prevent and collect overpayments and defaulted loans?

Mr. REYNOLDS. My problem in answering the question is that I am really not in a position to talk to how the resources are used in totality. In terms of the amount of resources currently applied to the collection of debts, they are obviously insufficient and need to be increased substantially. Whether there are sufficient resources within the agency to do that or whether that means you would have to increase the size of the agency, that's what I don't have an answer to.

Mr. STEINBERG. Would you be able to give us more information on that for the record?

Mr. REYNOLDS. I will try.

[Subsequently, the Office of the Inspector General submitted the following information:]

Our audits have concentrated on the prevention of overpayments and the collection process. We have not evaluated the budgetary or staffing resources necessary to effect significant improvements in collections.

However, some comparative data between VA and the Department of Education gives some perspective on the magnitude of VA resource needs. In fiscal year 1978, the Office (now Department) of Education hired consultants in the field of debt collection to review existing procedures and train personnel in such techniques as skip tracing and telephone collection. Approximately 1,000 full-time personnel were hired on 4-year temporary commitments. Collection letters were simplified and revised to provide greater visual and psychological impact. Monthly billing, similar to that used by credit card companies, was begun to provide a monthly reminder of

the debt obligation. Commerical collection agencies are used to pursue difficult cases where Office of Education collection efforts have failed to put defaulted loans into repayment. A "skip trace" activity was established to relieve collectors of the responsibility of locating debtors. As of July 31, 1979, the Office of Education had 52 FTE processing claims and 1,099 FTE pursing collection actions on 546,407 accounts receivable worth $658,784,836.

This contrasts to VA collection efforts which are limited and mostly passive. Eighty-five percent of the agency's total active accounts receivable for compensation, pension, education, and loan guaranty is the responsibility of CARS, the agency's centralized accounts receivable system. As of June 1979, CARS was maintaining 559,851 accounts receivable worth $503,878,284. Staffing for CARS consists of 147 FTE plus limited support from the regional offices. The 147 FTE are divided into three basic functions. A Support Operations Unit has 17 employees who process credit reports and VA employee accounts, resolve unidentified, unassociated, unapplied remittances, and control all input and output to the DPC St. Paul. A Referral Unit of 11 employees refers accounts receivable to GAO and DOJ. The remaining 119 employees are responsible for collection activity which consists mainly of deciding which demand letters to send. Thus, for approximately the same number of accounts, the Department of Education collection efforts are about ten times more intensive.

Another indication of resourse requirements is the estimate of the Department of Veterans Benefits of the resource requirements if H.R. 5288 is passed. This proposed legislation would permit the VA to use Consumer Reporting Agencies as a debt collection mechanism, and to affect the credit of verterans who do not respond to collection action.

This would result in increased accounts receivable action. The Department of Veterans Benefits expects an extensive beginning effort to pursue collection action on present inactive accounts. There would be decreasing staff and budgetary requirements each consecutive year. Estimated staff and funds needed for each fiscal year are:

[Dollars in millions]

Fiscal year	Man years	Amount
1981	494	$11,106.1
1982	381	6,653.5
1983	256	4,605.8
1984	117	2,408.8
1985	94	1,927.1

This estimate does not include any costs which would be incurred by the General Counsel, or Data Management and Telecommunications. In addition, there are no costs included for, or as a result, of affecting the veteran's credit rating.

Chairman CRANSTON. The pension benefits accuracy study, PBAS, published in 1978 indicated that the error rate in the VA pension program was 26.2 percent, 15.9 percent underpayments and 10.3 percent overpayments. At your confirmation hearing, I challenged you to reduce the 26.2 percent error rate by 50 percent. A most troubling aspect of the inaccuracies is the $20 million in net underpayments to pensioners 71 years of age or older.

However, in your May 5 report, you indicated that full implementation of the pension verification program, which had been scheduled to become operational in the fall of 1980, has been deferred until 1981 because of the commitment of resources to other projects.

In view of the limited financial resources available to those eligible for pension benefits, it seems to me that this verification is particularly important with regard to underpayments in the pension program.

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Is there any risk, in light of possible budgetary constraints, that the verification program will not be fully implemented in 1981?

Mr. REYNOLDS. I have not discussed that with the Chief Benefits Director or the ADP people. I do not have an answer, Mr. Chairman. I would be glad to try to get one and supply it for the record.

Chairman CRANSTON. Please do that.

[Subsequently, the Office of the Inspector General submitted the following information:]

In 1980, conversion of the Compensation and Pension System to the Honeywell environment as well as legislative priorities have precluded the completion of the Pension Verification Program. The Chief Benefits Director and the Assistant Administrator for Data Management and Telecommunications have indicated that the program will be fully operational in 1981. The computer-generated sample will be completed in late March 1981. The field work and adjudicative action will be completed by November 1981.

Chairman CRANSTON. Have you conducted any studies of the pension program with respect to requests for waiver of overpayment?

Mr. REYNOLDS. No, sir, we have not.

Senator STAFFORD. Mr. Chairman, I could address a question at sometime at your convenience.

Chairman CRANSTON. Why don't you do it now?

Senator STAFFORD. All right. Mr. Reynolds, as Inspector General, if any investigations into the possibility of some kind of fraud in the buildings program of VA occurred, it would fall to your office to conduct that investigation, would it not?

Mr. REYNOLDS. That's correct, Senator, yes.

Senator STAFFORD. Have there been such investigations in any of the building programs that you are aware of?

Mr. REYNOLDS. Yes; there have been several. One involved improper insulation and entailed not only a single location but a search effort to see if we had a similar problem elsewhere.

Another one involved allegations by a resident engineer, a VA staffer, against resident engineers and others about the quality of construction in a facility. There was extensive technical aspects being challenged. We brought in Corps of Engineer people to help us in that particular investigation.

I think the only other thing is that we have had continuing audits and investigations on the loan guarantee program.

Senator STAFFORD. You are aware of some of the difficulties GSA has had with respect to leasing office space for Government employees and construction of office space and the fact that there appears to have been some difficulties with respect to some of these leases and construction programs.

The Veterans' Affairs Committee of the Senate and its counterpart in the House have now undertaken the responsibility with respect to prospectuses for building and leasing that the Environment and Public Works Committee takes with respect to GSA. I think this is an area that both the Committee and the Veterans' Administration and your office should exercise a lot of caution so that if any malfeasance is occurring, it will be discovered before it embarrasses either you, the Veterans' Administration or the members of this Committee who might sign a prospectus.

Chairman CRANSTON. Particularly the latter. [Laughter.]

Senator STAFFORD. That's right, and I might say, Mr. Chairman, I am sensitive to this because Jennings Randolph and I have been the two who have been signing prospectuses up until a year ago and we simply imposed a moratorium on further prospectuses in our Committee except in real emergency situations and I hope that situation can be avoided in this Committee. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much.

There appears to be a substantial disagreement between you and DVB as to the amount and type of additional information that should be provided pensioners on unreimbursed medical expenses which is the largest cause of pension underpayments.

I definitely believe that much more detailed information should be provided pension beneficiaries in this regard and I don't think that the check stuffer alert to advise pensioners to contact the VA if they have questions in this area is by itself an adequate response to this problem.

Have you given up on your efforts to get more detailed, printed guidance out to pensioners on this item?

Mr. REYNOLDS. Not entirely, no, sir. It is a very complicated item. As we pointed out, when you talk about medical expenses in the Tax Code, for example, you can look at the taxpayer guidance and find six pages of finely printed detail. It is a very difficult item to communicate with people on.

There can be, we think, more media coverage, but I think it would still come down very often to the need to encourage people to talk with a counselor in order to get the right answer.

Mr. STEINBERG. You reported on two audits matching beneficiary records by social security numbers and identified 95 educational assistance beneficiaries and 321 compensation and pension beneficiaries who were apparently receiving double payments. Prompt corrective and remedial actions were taken.

Shouldn't the DVB itself make such checks periodically?

Mr. REYNOLDS. Yes, and arrangements have been made for them to use the routines we use in the future to make such checks periodically.

Mr. STEINBERG. So they will be doing it periodically in the future?

Mr. REYNOLDS. That's right.

Mr. STEINBERG. Your current semiannual report indicates that DM&S needs to strengthen hospital implementation of VA's patient abuse policies. What specific recommendations did you make in this regard and have they been implemented?

Mr. REYNOLDS. Mr. Busbee?

Mr. BUSBEE. I don't recall the specific recommendations we made in the patient abuse report but we did make some specific recommendations and we are following up to make sure they are being implemented and I will be glad to furnish those for the record. Increased training is one, increased supervision.

Chairman CRANSTON. I'm sorry, but I have to leave for the majority leader's office to discuss the current status of work in the Senate. I hope to get back. Jon Steinberg will carry on and Senator Stafford also has to leave on another commitment shortly.

Mr. Reynolds, if you can stay for the rest of the hearing after you are finished answering questions and return to the witness table at the end to respond to the testimony we have received in the course of this morning's hearing and any other questions that might come up, I would appreciate it. I hope to be back for that phase of the hearing but I'm not sure I will be. Thank you very much.

Mr. REYNOLDS. Thank you, sir.

Mr. STEINBERG [presiding]. Mr. Busbee, will you follow up on that patient abuse issue for the record and also indicate for the record, with respect to the Waco, Tex., investigation specifically what disciplinary action was taken in the 9 or 10 instances where you found that allegations were sustained as far as patient abuse is concerned and whether or not the disciplinary action taken was sufficient in your judgment? Also, please indicate whether it was the minimum or maximum recommended action or where it stood in the range?

Do you have any comments on that that you wish to make now?

Mr. REYNOLDS. Let us respond for the record. I am not sure that disciplinary action has actually been taken yet but we made recommendations and we will give you that.

Mr. STEINBERG. Thank you.

[Subsequently, the Office of the Inspector General submitted the following information:]

The Department of Medicine and Surgery has not yet implemented any of the 10 recommendations contained in our December 1979 audit report on Patient Abuse. The Department is currently developing a circular which is intended to address all recommendations except one, but was unable to provide a target date for the circular's issuance. According to DM&S officials, staffing shortages in the office responsible for patient satisfaction surveys have indefinitely delayed implementation of recommendation 4. Following are the 10 recommendations we made:

1. That DM&S instruct those medical center directors who have not formally adopted VA's patient abuse policy in their local policies to take immediate action to do so.

2. That DM&S establish procedures to assure that all medical center employees review at least annually VA's patient abuse policy.

3. That DM&S conduct periodic reviews to assure that VA's patient abuse policy is reflected in local policies and communicated to employees.

4. That DM&S instruct all stations to adopt and use the standard VA patient satisfaction survey forms when conducting patient surveys.

5. That DM&S improve its timeliness in reporting patient satisfaction survey results to individual medical centers.

6. That DM&S encourage medical centers to prepare written MOD reports to assure that all suspected incidents of patient abuse are easily identified and investigated.

7. That DM&S instruct medical center directors to make sure sufficient and complete data is provided on VA Forms 10-2633 to adequately describe patient incidents and that the patients involved are interviewed to determine the accuracy of reported data.

8. That DM&S encourage medical center directors to have their employees initiate VA Forms 10-2633 for all special incidents involving patients, including outpatients.

9. That DM&S emphasize to medical center directors the importance of properly preparing and filing Summary of Special Incidents reports.

10. That DM&S encourage medical centers to adopt a training program dealing with patient abuse prevention and the handling of difficult patients for all employees who have contact with patients.

A related audit at VAMC Waco raised particular concern regarding the administration of the patient abuse program. This, coupled with a "hotline complaint", led to an investigation at the medical center. Our investigation was completed on May 23, 1980.

The actions to be taken as a result of our investigation of patient abuse at the VA Medical Center, Waco are presently under consideration in the Department of

Medicine and Surgery. We have recommended the removal of two employees, the counseling and closer supervision of a third and that all Nursing Service personnel be reminded of their responsibility to promptly report patient abuse. We feel that these are the appropriate actions which are supportable by the evidence developed in this case.

Mr. STEINBERG. In your semiannual report, turning now to matters relating to loan guaranty on page 1-6, you stated that the extent of detected program fraud and abuse is greater in the loan guaranty program than in any other VA program. You also noted that you completed and turned over to the Department of Justice the results of multiple investigations of seven lenders and that program officials identified 157 cases which were referred through the VA district counsels to the Justice Department.

Your report also indicates that as of December 31, 1979, loan guaranty indebtedness had risen to over $138.7 million. The report further indicates that during the first quarter of fiscal year 1980 almost $7.5 million in new indebtedness was established and that only about $3.8 million in indebtedness was disposed of by collection and offset against other benefits, waiver and compromise or termination of collection activity.

These and other problems you noted suggest that the loan guaranty program is in need of considerable attention, it would seem to us. However, at your confirmation hearing, you indicated that due to time and staffing considerations, in-depth investigations of the loan guaranty program were not feasible and that a type of "flying squad approach" would be used in the future.

Thus, instead of investigating a large number of cases in any single office, the IG's office would review fewer cases in multiple offices.

Please describe the "flying squad approach" now and in more detail for the record.

Mr. REYNOLDS. The "flying squad approach" is directly tied to the recommendations we made for establishing files by lending institution and accumulating information by lending institution and reporting it to Washington so patterns and trends could be identified and it would be from that base of information that we would address the most serious looking questions.

That base of information is just developing. We have the first quarter's data and we have looked at it and there is nothing in there yet of enough significance to warrant assigning an investigation. But we are still going to approach it this way and we will also continue to approach specific project situations such as our joint effort with the Department of Housing and Urban Development in Puerto Rico where we have a serious problem involving a number of lenders at a single site location.

[Subsequently, the Office of the Inspector General submitted the following information:]

Our previous loan guaranty task force activities in five cities involved the stationing and typing down of significant temporary investigative manpower for long periods in these cities alone in a rather slow moving process of developing large numbers of cases involving multiple lenders and brokers.

By early 1979, we included that we did not have the staff positions, some of which were borrowed and had to be returned, to continue this approach. Further, the potential deterrent impact of such an approach was essentially localized, or regional at best, rather than of a national nature. Thus, we adopted the flying squad approach as a more suitable alternative.

The flying squad approach entails the pre-identification of suspect lenders and brokers through the new DVB control system and other techniques employed by my office and then targeting on one or two lenders or brokers in a specific location. A team of investigators under the direction of our Central Office Special Operations Staff will then conduct "quick hit", highly concentrated, investigations of one month duration or less. This gives us much broader geographic coverage with fewer people and we anticipate that such coverage will provide a stronger deterrent effect.

Mr. STEINBERG. Senator Thurmond?

Senator THURMOND [presiding]. I will pass for the moment.

Mr. STEINBERG. The chairman has asked me to carry on with the questions he would ask when he was called away. If there is no objection, I will proceed to do that.

Senator THURMOND. No objection.

Mr. STEINBERG. Thank you, sir.

Do you believe that this "flying squad approach" is doing the job adequately in the loan guaranty area?

Mr. REYNOLDS. As I say, we don't have the data base to work from the "flying squad approach" yet and we don't know for certain. It seems to me though that we have learned as we have undertaken task force efforts in these towns that the word gets around pretty fast and the feedback we get is that it does have an impact on the local community in terms of forebearance of this sort of activity.

It just struck us that we could get more impact with the resources we have if we tried to spread that forebearance atmosphere around the countryside more rather than investing so much by way of resources in a single site. It is sort of a commonsense thing.

Mr. STEINBERG. What recommendations have you made to prevent loan defaults and to improve collection action on loan guaranty accounts receivable?

Mr. REYNOLDS. We have been working in that area. It was one of the later areas we addressed. We concentrated on accounts receivable first. I am trying to remember if we have our recommendations out yet or not. I don't believe they're out yet but I have some notes on the general thrust of those recommendations.

Mr. STEINBERG. Are you in the process of discussing those with the Department of Veterans' Benefits?

Mr. REYNOLDS. Yes, we are. I thought I had some notes on it, but I don't.

Mr. STEINBERG. Would you provide it for the record when you are able to do so?

Mr. REYNOLDS. Yes.

[Subsequently, the Office of the Inspector General submitted the following information:]

In an interim audit report covering selected aspects of VA's Loan Guaranty Program, we are planning to make several recommendations in the areas of loan default, processing and property management. We believe that implementation of the recommendations should improve the cure rate on defaulted loans (thus enabling the veteran to keep his home), and reduce the incidence of defaults because of better monitoring of credit underwriting procedures. Pending review and consideration of the Department of Veterans Benefits, comments to this report, our recommendations are tentative and consist of the following:

1. We found the required number of postaudit reviews by regional offices were not always performed and that postaudit employment and deposit verifications were not adequate. We will recommend:

(a) That postaudit precedures be improved by assessing reported data and advising those offices not meeting minimum requirements for selecting cases for postaudit

that they are to increase such activities to obtain the prescribed 10 percent coverage.

(b) That postaudit procedures be improved by: (1) revising forms and form letters used to request postaudit verifications to assure uniformity and improve response rate; and (2) revising DVB Manual M26-1 to provide instructions for follow-up actions when requested verification information is not received.

2. Concerning defaulted loans, we found problems of timeliness, inadequate supplemental servicing by the regional offices, and default appraisals not reflecting market value at one regional office. We will make the following recommendations to alleviate these problems:

(a) That DVB take action to ensure that mortgage holders give notice to the VA within 105 days after any debtor defaults.

(b) That DVB timeliness standards for input of Notice of Default information into the Liquidation Claims System be clarified.

(c) That DVB: (1) re-emphasize the need and responsibility for adequate, timely supplemental servicing, and (2) take action to ensure that all regional offices review Notices of Default and initiate personal servicing when the holder's servicing has been inadequate.

(d) That DVB take action to ensure that: (1) all regional offices provide accurate default appraisals, and (2) non-upset bids are submitted when appropriate to minimize losses to the VA.

3. Because of problems concerning reviews of fee appraisers and compliance inspectors by VA regional office staff, problems in assuring appraisal accuracy, and problems in performing timely property analysis, we will make the following recommendations to the Department of Veterans benefits:

(a) That DVB take action to ensure field reviews of fee staff at all regional offices are effectively accomplished.

(b) That DVB take action to ensure that all regional offices instruct fee appraisers to compare VA, FHA and conventional sales.

(c) That DVB take action to ensure that initial property analyses are conducted within VA timeliness guidelines at all regional offices.

Our Audit of the Centralized Accounts Receivable System (CARS) has resulted in recommendations that we believe will improve collections of loan guaranty accounts receivable (as of March 31, 1980, $110.6 of the $143.7 million loan guaranty accounts receivable were contained in CARS). However, we have not yet received and reviewed comments on this draft report.

Because of the passive nature of this collection system we are recommending that a telephone test by dollar ranges, and by type of account be attempted as well as more personal contact be used in the collection effort.

Other recommendations directed at improving collection activity include:

1. Pursue collection action against all terminated accounts that can be identified as servicepersons.

2. Develop programs to match all active and terminated accounts receivable records against VA and other Federal agency personnel records. This latter effort is being done under the auspices of the Inspector General's office.

3. Emphasize voluntary or involuntary payroll deductions to collect debts from VA employees.

4. Request other Federal employing agencies to keep record of the debt in debtor's finance records and offset debt when employee is separated from government service.

Mr. STEINBERG. Do you consider that DVB has made adequate efforts to address problems in the loan guaranty program identified by your audits and investigations and to implement recommendations made by your office regarding that program?

Mr. REYNOLDS. Generally speaking, DVB has been quite effective in addressing the recommendations we made. In response to the first part of your question, are they doing an adequate job, we find that it varies from regional office to regional office depending on the degree of emphasis this area is given. We found situations such as the transfer of deeds being—sort of a wait-for-them-to-come-in approach and some offices take 120 to 140 days, whereas other offices aggressively sought the transfer of deeds and were getting them in 40 to 50 days. There is an unevenness in the program administration.

Mr. STEINBERG. Mr. Reynolds, as you are certainly keenly aware, an essential aspect of the Inspector General Act of 1978 is to create the offices of Inspectors General as independent and objective units. Have there been any instances in which the independence of your office has been impaired in the VA?

Mr. REYNOLDS. No; in my judgment there is not. I recognize that GAO has some feeling otherwise, but in my judgment there has not been.

Mr. STEINBERG. Section 5(a) of the act requires the Inspector General to prepare semiannual reports to the agency head who in turn is to submit them to the appropriate congressional committees within 30 days together with the agency head's report and comments.

Has the Administrator or any other VA official in any way interfered with or delayed the submission of these reports to Congress?

Mr. REYNOLDS. No; they have not. However, the actual release dates by the Administrator have been a day or two late on a couple of occasions.

Mr. STEINBERG. Has your report been presented to the Administrator in a timely fashion?

Mr. REYNOLDS. On the first two reports, we met the month end prescribed period. On the last report, we were 2 days late. Generally, yes.

Mr. STEINBERG. Has the Administrator or any other office within the VA interfered with your activities or attempted to influence you to modify the contents of any of these reports?

Mr. REYNOLDS. No. Let me qualify that. When we staff a report, we submit a report in draft. We do this to obtain comments and further identify any differences. That process might lead us to recognize that what we are proposing to say is not the right answer. On occasion, our facts are wrong unfortunately and we have to send someone back to straighten it out. That is in the clearing process of producing a credible product.

Mr. STEINBERG. But you separated your process into investigative findings on one hand and investigations on the other and, in this case, we're talking about findings and the answer is that there was no attempt to interfere or any interference as far as your findings are concerned?

Mr. REYNOLDS. Not as far as I know.

Mr. RETTEW. Occasional disagreement which we resolve but not interference.

Mr. STEINBERG. Has there been a specific objection to the contents of your reports insofar as findings are concerned by the Administrator or any other office within the VA? Again, not speaking of recommendations for what ought to be done with respect to findings.

Mr. REYNOLDS. I can't think of any.

Mr. BUSBEE. We have had disagreement on the findings, but no objections.

Mr. STEINBERG. So the reports have been made by you and made available publicly by you with the findings you believe are warranted?

Mr. REYNOLDS. That is correct, yes.

Mr. STEINBERG. Section 6(a)(6) of the act provides the Inspector General with an independent appointing authority; section 6(a)(7) of the act authorizes the Inspector General to obtain the services of experts and consultants; and section 6(a)(8) authorizes the Inspector General to the extent provided in advance by appropriations to enter into arrangements for audits, studies and other services with public agencies and private persons.

Have you exercised these authorities with complete independence?

Mr. REYNOLDS. Yes, sir, I have.

Mr. STEINBERG. To what extent has your office used these experts, consultants, and contract authorities?

Mr. REYNOLDS. We have not used experts, consultants, and contract authorities but rather we have borrowed experts from other Federal agencies and from the VA where there was not an independence problem. I mentioned earlier, in response to Senator Stafford, that we borrowed engineers from the Army Corps of Engineers to assist us, for example, on construction problems.

Mr. STEINBERG. Have you contracted specifically for audits to be carried out by private firms or public agencies?

Mr. REYNOLDS. We have not done so yet, but we are moving in that direction as rapidly as we can. We have some 30 States interested in doing that with us so far and we are working to establish such contractual arrangement.

Mr. STEINBERG. Do you have the resources to do that in terms of dollars available?

Mr. REYNOLDS. I think we have enough to squeak by with what we are going to be able to do this year and we will have to take a close look at next year. We have specific line items, if you will, in our 1982 budget proposals.

Mr. STEINBERG. When it is appropriate, would you comment further on what you think your fiscal year 1982 requirements will be in that regard?

Mr. REYNOLDS. OK.

Mr. STEINBERG. If you can make certain magnitude estimates available to us in advance of submission of the budget, we would appreciate that.

Mr. REYNOLDS. We can tell you now that we think we are talking in the range of about $200,000.

Mr. STEINBERG. How many contracts would that provide for?

Mr. REYNOLDS. About 30.

Mr. STEINBERG. Are you referring to State programs such as the State homes program?

Mr. REYNOLDS. Yes.

Mr. STEINBERG. In your semiannual report, you indicate that you are reducing the frequency of your cyclical audits of medical centers from every 3 years to every 5 years. What adverse effects, if any, do you believe this change would have on the overall audit function of maintaining quality management and timely identification of problem situations?

Mr. REYNOLDS. I think that it lessens the influence that audit might have as a deterrent value. Someone who knows that their activities will come under audit is likely to behave a little differently than someone who doesn't. If there is a 5-year interval, there

is the real possibility that the management, key people, come and go without ever having their activity subject to an audit where they are in effect defending their activities and operations.

If you get much beyond 5 years, the deterrent value in my judgment is virtually totally lost. At the 5-year frequency level, I would say it is lessened. I think what is also lessened is our ability to identify across-the-board problems, what we call trend analysis. We just don't have as big a base to work on when we reduce the frequency of our audits.

I might say when we talk about medical centers in particular, we are talking about a large complex operation. Average operating costs about $30 million a year. We are talking about spending in the range of 25—$35,000 to $40,000 for an audit, once every 3 years or once every 5 years, depending on resource capability.

Mr. STEINBERG. What additional resources would be necessary in order for you to continue at a 3-year interval?

Mr. REYNOLDS. For the medical centers alone, we would be looking at 33—33 is the number. If we were talking about a 3-year cycle for all VA activities and operations and functions, we are talking about 98.

Mr. STEINBERG. How many additional dollars for the 98?

Mr. REYNOLDS. $3 million probably, in the range of $3 million.

Mr. STEINBERG. Do you intend to seek those additional resources for fiscal 1982?

Mr. REYNOLDS. Not to that extent at this point in time. I don't find that there is much practical opportunity to go that far. We will try to establish some added capability along the line of saying that we have some capability at least to do some of these facilities on more than a 5-year cycle.

There are some facilities that have serious problems and ought to be looked at more frequently. If you put everything on a 5-year cycle, that means we have to slip some others that we don't know anything about in order to go back to one we know we should go back to. We are asking for resources least sufficient to allow us to do more frequent audits at facilities that have the most serious problems.

Mr. STEINBERG. To what extent are you able to ameliorate the lack of deterrents you referred to by your reactive audits? That is, if it should turn out that you have not been to a facility for 3 years and you decide that you have to carry out an investigation there in response to a particular complaint, are you able to marshal resources to perhaps partially go back into certain issues or is that just not efficient or effective?

Mr. REYNOLDS. We really haven't been able to do very much, if I understand your question. We have had to say pretty much to our people, this is the agenda for the special audit and we don't have the time or manpower to go beyond the agenda. Certainly we would expect that if auditors are there and get wind of serious problems that they report this to us and we would see what we could do about setting up another audit project, if you will, to address the problem.

Mr. STEINBERG. Senator Thurmond?

Senator THURMOND. Thank you. Mr. Chairman, I ask unanimous consent that an opening statement by me follow that of the chairman.

Mr. STEINBERG. Since you are the chairman, that certainly will be done.

Senator THURMOND. Mr. Reynolds, we welcome you here this morning and I just have a few questions. You are the Inspector General of the Veterans' Administration, what title do you go by, Inspector or General, I want to address you in the proper way?

Mr. REYNOLDS. Inspector General.

Senator THURMOND. Inspector General, on page 2 of your testimony, you state that additional tests would be necessary to further reduce the balance of accounts receivable. What are these additional initiatives being considered? You state that extensive and time-consuming changes to computer systems will be needed.

Will you explain this, do you have any cost estimates for these new initiatives?

Mr. REYNOLDS. No, sir. I attended a meeting the other day and one of the purposes of the meeting was to put the ADP people to work coming up with these preliminary estimates on both the time and cost, type of hardware needed, et cetera. It is clear that this is quite an add-on to the system and it will take rather significant adjustments to adapt to it. But the process of getting actual numbers together on what that amounts to is still under study.

Senator THURMOND. Will you need new equipment, more modern equipment?

Mr. REYNOLDS. My understanding of what the ADP people were saying is that there is not the capacity on existing equipment to do this. They will have to get additional equipment.

Senator THURMOND. How many people work under you?

Mr. REYNOLDS. 353 people.

Senator THURMOND. 353 people work under the Inspector General?

Mr. REYNOLDS. Yes, sir.

Senator THURMOND. Do you think it will take that many to do the work of the Inspector General? You see, this is a new department and Congress has been trying to reduce the cost of Government and reduce personnel. That's a pretty big increase, isn't it?

Mr. REYNOLDS. Well, it is. As I pointed out, not in my opening statement but in going through my opening statement as an aside, in those things we can quantify of the results of our effort, in the past year we can identify $38 million of savings attributable to the operations of our office. I think the true savings are much greater than that.

Senator THURMOND. $38 million you say? What is the cost of your office?

Mr. REYNOLDS. About $10½ million or $11 million.

I think the true savings is broader than that. We were talking a few moments ago about deterrent value which comes with a cost, but you can't price the benefit. There have been initiatives taken and I think the challenge of this committee to reduce accounts receivable, while the fact is that accounts receivable were not reduced, the efforts to try to do it and initiatives taken, not just by my office but other offices on their own initiative, was quite exten-

sive and I think stem from the knowledge of the viewpoint of this committee of the need for such efforts.

I think the Inspector General's Office a very necessary function and quite frankly I don't think it is large enough.

Senator THURMOND. Will these new changes you referred to occur within the current TARGET system, or will additional computer capability be required?

Mr. REYNOLDS. That will depend on the ultimate decision as to where the accounts receivable records will be kept.

Right now, a portion of them are kept in what is called the Hines system which is part of TARGET and will be merged into TARGET. The balance is kept at St. Paul on a system called CARS. So the answer to your question is based on where they decide ultimately those accounts receivable will reside and that decision has not been made as I understand it.

Senator THURMOND. Testimony has been received from several witnesses who state that the IG staff has been heavy handed in their auditing procedure. I realize that many auditing or investigating procedures will be inconvenient on those affected. Has the VA solicited responses from those medical centers and regional offices regarding the actions of the IG staff?

Mr. REYNOLDS. My understanding is that at least the Department of Veterans' Benefits, in preparing for today's testimony, has solicited such testimony. I do not know whether the Department of Medicine and Surgery has made a similar solicitation. However, to the best of my knowledge, the cases, criticism about our operations which have come up, are known by both myself and my staff and the appropriate departments or staff offices concerned.

Senator THURMOND. I presume you will see that your auditors and inspectors are courteous and try to give people as much reasonable notice as you feel should be given. For instance, doctors are very busy, medical personnel are especially busy. Perhaps they might need reasonable notice to get their files in shape or whatever is necessary.

Could you make the VA Central Office reports available to the committee regarding the assessment of Inspectors General visits?

Mr. REYNOLDS. Yes, Senator, we'll do that.

Senator THURMOND. I want to ask you this. Last year it was reported that almost $400 million in education overpayments had been made by the VA. Have you had occasion to look into that?

Mr. REYNOLDS. Yes; we looked into it extensively. In fact, in the whole area of overpayment and collection, we invested almost 10 percent of our audit resources this last year working on these problems and trying to find solutions.

Senator THURMOND. Did you find whether the figure is correct or not?

Mr. REYNOLDS. The figure is basically correct, yes, sir, and we have made some suggestions that will reduce the amount of overpayment occurring.

Senator THURMOND. Have you taken steps to correct or recover overpayments?

Mr. REYNOLDS. We have again made recommendations, many of which have been implemented, to collect overpayments as well.

Senator THURMOND. Who do you make recommendations to?

Mr. REYNOLDS. In all instances, our recommendations are basically to the department head but also the Administrator.

Senator THURMOND. Who is the department head for overpayments?

Mr. REYNOLDS. Department of Veterans' Benefits has responsibility for administering that program.

Senator THURMOND. Will it be your duty to take steps to recover this $400 million or are you just making recommendations to somebody else about it?

Mr. REYNOLDS. We make the recommendation to somebody else. We are not in the collection business ourselves.

Senator THURMOND. You do not have the power to take steps to recover this money?

Mr. REYNOLDS. Not within the authority of my office.

Senator THURMOND. But you have the power to see that they do?

Mr. REYNOLDS. Yes, sir.

Senator THURMOND. Are you doing that?

Mr. REYNOLDS. To the best of our ability we are; yes.

Senator THURMOND. Is your ability sufficient, are you doing the job? If not, do you need more help or why not?

Mr. REYNOLDS. In that area, it's not a matter of more help. We were discussing a little earlier, the Government is generally working with very weak capabilities to collect accounts receivable. Insufficient staff assigned to actually try to collect money, insufficient authorities to collect money, lack of simple access to locator information to find the debtors and be able to use that information.

It's these sorts of problems that underlie why I think you have these types of dollars that you see there. Actually, $400 million is a very significant amount and I don't want to minimize it at all. But I think it should be pointed out that $400 million is about 1 percent of the total benefits paid out on this program from its inception. As a percentage of the total program, it's not that bad.

Mr. STEINBERG. If I might, Senator, that's an accumulation, that's not just 1 year's.

Mr. REYNOLDS. That's correct.

Senator THURMOND. The authority of your office and the zeal with which you go about encouraging these people to pay would have its effect, wouldn't it?

Mr. REYNOLDS. Yes, sir.

Senator THURMOND. Do you intend to push for recoupment, and recover this money for the taxpayers?

Mr. REYNOLDS. Yes, and I think we have been doing so, sir, just about as hard as we can.

Senator THURMOND. I notice last year it was reported that the VA had overpayments in education of about $8 million—I mean $8 million of education loans were in default. Have you taken steps to recover that?

Mr. REYNOLDS. No; the VA system for collecting those default loans is very weak. We have just finished audit work in that area and we will make recommendations that we hope will tighten up that system but that program is a real problem in terms of its track record.

Senator THURMOND. It's been very poor, hasn't it?

Mr. REYNOLDS. It's been terrible.

Senator THURMOND. Do you think you can make recommendations that will make it effective? Why can't the Government go at these things like a business goes after a debt? After all, this is a debt due the taxpayers.

Mr. REYNOLDS. Basically, that is my feeling also, I think we really need to approach it the way the private sector approaches it but in point of fact the Government has inhibited itself by some of its laws and some of its policies and some disagreements between agencies even.

Senator THURMOND. If you need help from the Congress, we can do something about it. Or, perhaps report to the Administrator of the Veterans' Administration and if he won't do anything, maybe to the Office of Budget and Management and if they don't do anything, to the Congress so we can find where the trouble is and try to correct it.

Mr. REYNOLDS. I feel we have done all of those things to some extent at least. Maybe not everything, but we have covered some of the major features. We have either done it or seen that it was done.

Senator THURMOND. How much still remains from this $8 million that I referred to that is uncollected?

Mr. REYNOLDS. It's actually—I believe the number you are referring to is $23 million. Education default rose from $8 million to $23 million and nothing happened to it. It's defaulted——

Senator THURMOND. And you are taking steps and making recommendations along this line, and you intend to pursue it vigorously?

Mr. REYNOLDS. Yes, sir, we do, and I will be glad to provide a report of that in our recommendations.

Mr. STEINBERG. You've agreed to do that already.

Senator THURMOND. A recent newspaper article states that the VA reached an out-of-court settlement of $683,000 with representatives of a disabled veteran who suffered irreversible brain damage due to loss of oxygen while being treated at a VA hospital here in Washington. Has your office investigated in this instance the policies of the VA in connection with matters of this kind; and, especially concerning out-of-court settlements and have out-of-court settlements been reasonable and have you investigated whether or not steps have been taken by the VA to remove people guilty of negligence in those matters? In other words, what steps have you taken concerning claims against the Government for negligence on the part of VA employees?

Mr. REYNOLDS. We have taken no steps with respect to that specific case. We have not conducted any audits or investigations pertinent to that specific type situation in the past year. We have not looked into the tort system.

Senator THURMOND. Wouldn't this fall within the sphere of your responsibility?

Mr. REYNOLDS. I think for some of your questions the answer is yes and I think for some of your questions the answer is no. I think the issue of whether or not malpractice existed, the issue of what sort of appropriate disciplinary action is taken and so forth really falls outside the sphere of our activities beyond looking to see whether the right processes were followed.

Was there a board hearing, consideration of the performance of the doctors, et cetera. Again, the question of administrative processes with respect to tort claim settlements and that sort of thing can be looked at. But we don't have the professional expertise to assert an independent professional judgment into that sort of situation.

Senator THURMOND. You could hire expert professional people who could do it for you. I was under the impression, and I think the Senate was also, that when we set up these inspectors general that they were really going to see what is going on in these agencies and take steps to correct things that were not right.

Mr. REYNOLDS. I think though that both the act itself and the legislative history shows that it was intended that the inspectors general would concentrate their attention on issues of efficiency, economy, fraud, and waste. There is an intent established in the hearings on the Inspector General Act that cites specific examples and points out that it is not expected that the jurisdiction of the inspectors general will be unlimited.

It goes further and identifies that it is not expected that he will have expertise, for example, that would allow him to look into the quality of performance of a sewer treatment plant, which happens to be the actual example in the record. I must say that I think that the Senate and the House, in voting on this legislation, created a record which suggested that they did not want something quite as broad as you are supporting, Senator, in terms of the scope of our activities.

Senator THURMOND. Who is going to do it if you don't do it?

Mr. REYNOLDS. Under the law, title 38, the Chief Medical Director has direct responsibility for professional care in the Veterans' Administration.

Senator THURMOND. You don't have any inspection of his responsibilities?

Mr. REYNOLDS. We do, but it is a question of whether we should have an inspection of his responsibilities where the issues drawn are purely quality of care issues which is the nature of this case as I read about it in the newspaper.

Senator THURMOND. It strikes me it would be well worth while for the inspector general to look into these matters with the different heads of the departments within the VA. It might be determined that steps do need to be taken to employ professional people to do this work. The head of the whole medical VA setup would be appreciative along that line of any help he could get.

Mr. REYNOLDS. We have conversation this morning about what is called the medical inspector which is a proposal to establish a doctor reporting directly to the Chief Medical Director who has oversight over all quality of care issues and he would be closely coordinating his activities with my office.

Senator THURMOND. He would be responsible to you?

Mr. REYNOLDS. No; he would work with the Chief Medical Director but those activities where we cross the line between quality of care, fraud, abuse, and waste issues——

Senator THURMOND. So the Department of Medicine and Surgery would not be under you at all?

Mr. REYNOLDS. That is the proposal being considered, that is correct.

Senator THURMOND. I'm a little surprised to hear that any particular part of an agency will not be responsible to the Inspector General.

Mr. REYNOLDS. If I may, in the sense of our looking at what that medical inspector is doing, the quality of work that he is carrying out and so forth, this would be under our jurisdiction. It would be subject to audit and investigation just as any other activity of the VA. But my understanding of your question was, is it under my direct supervision and I would say no, it is not in the proposal.

Senator THURMOND. It seems to me somebody has to be responsible for the internal inspection of the department, and that means the whole department. It doesn't mean part of it; but all of it, and that is the impression that I think we had when we set up these Inspectors General. They were to be independent, subservient to no one, and they would see that everything was conducted in an efficient and honest manner. I suggest you think about that and look into it.

Mr. STEINBERG. Senator Thurmond, if I might interject a comment for your consideration? I believe it is correct that the armed services inspectors general each have within those inspectors general offices medical people who carry out medical inspections. Is that correct?

Mr. REYNOLDS. That is correct, it is my understanding and recollection as well.

Mr. STEINBERG. And that has existed for a substantial period of time, in each of the armed services—Navy, Army, Air Force. Have you talked to the Inspectors General of each of those services and specifically the medical people in those Inspectors General operations to find out what problems, if any, they have had in making those inspections effective?

Senator THURMOND. What I am interested in, you may have an Inspector General, for instance, the Surgeon General out of the VA probably has someone to do inspections. But he is still part of the VA and you are Inspector General for the whole VA. It seems to me that you would have responsibility for every facet of the VA in some manner to see that responsibilities are being met.

I have to go now, thank you very much.

Mr. REYNOLDS. Thank you, Senator.

Mr. STEINBERG [presiding]. What communications have you had with the armed services?

Mr. REYNOLDS. I've had none on the issue you have brought up.

Mr. STEINBERG. Has anyone in your office had those communications?

Mr. REYNOLDS. No.

Mr. STEINBERG. Has anyone in the Department of Medicine and Surgery had those communications?

Mr. REYNOLDS. Yes——

Mr. STEINBERG. I would imagine Dr. Custis is intimately familiar with that?

Mr. REYNOLDS. He is very familiar with it as was his predecessor.

Mr. STEINBERG. It is clear from the reaction you have had from Senator Thurmond which I think would not be dissimilar to the

reaction of many of the members of the committee that this particular proposal is one that deserves very serious consideration before it is finally implemented.

At a minimum, it would seem incumbent upon you to investigate the most nearly parallel situation in the Government and to report to the committee why that particular procedure is not considered appropriate for replication in the VA.

Mr. REYNOLDS. I will do so but I would explain that in the Department of Defense what is called an inspector general is not the same thing we are talking about. In other words, if you take the Department of Army as an example, you have an Army audit agency, you have an Army investigative agency and an Army inspector general.

The inspector general function is more of an inspection function than either audit or investigation. What I am trying to say is that within the Surgeon General's office, he has an inspector general but he is also subject to audit investigation. What I basically am is audit and investigation activity. In other words, the definition in our law of the inspector general is not the same as the military definition of inspector general. There is overlap admittedly.

Mr. STEINBERG. I'm confused. You used the term "Surgeon General."

Mr. REYNOLDS. Under the Surgeon General, there is an inspector general who works for him.

Mr. STEINBERG. Is that individual directly accountable to him and not the audit or investigative function?

Mr. REYNOLDS. That is correct.

Mr. STEINBERG. Is that the model you are attempting to replicate in the VA, to the extent that the Surgeon General is parallel to the Chief Medical Director?

Mr. REYNOLDS. To some extent, but as I said in the military setup, there is an overlap between the functions of the Inspector General and the functions of the audit agency, for example. Our proposal as I see it does not replicate that overlap, that duplication.

Mr. STEINBERG. But you are saying that the Inspector General in the Department of the Army, for example, does not carry out medical quality of care inspections. That that is carried out by an employee of the Surgeon General?

Mr. REYNOLDS. Who is called the Inspector General of the Medical Corps.

Mr. STEINBERG. But who is directly responsible to the top operating medical official, not to the top operating investigative official?

Mr. REYNOLDS. That is correct in my understanding, that's the way it was in the days I was there.

[Subsequently, the Office of the Inspector General submitted the following information:]

We contacted audit and investigation offices and Inspector General or other offices having a quality of care inspection mission in the Army, Navy and Air Force, with the following results:

1. Audit and Investigation units of the three military services do not undertake inquiries based on allegations of problems in patient care. Further, their emphasis on issues which might be considered as on the fringe of direct patient issues (for example, our audit of the controls to monitor the quality of care) seems to be far less.

2. The primary organizational responsibility for review of quality of care allegations in the three services is as follows:

Army.—The primary responsibilities for inquiry into allegations relating to quality of care are vested in the Health Service Command for Continental U.S. cases and in the Chief, Health Care Operations (who works for the Army Surgeon General) for overseas operations. The Army Surgeon General is a staff officer with no direct line responsibility for the Health Service Command which operates U.S. Army hospitals. Some highly sensitive investigations may be referred to the Army Inspector General.

Navy.—Quality of care investigations are the primary responsibility of the Inspector General of the Bureau of Medicines and Surgery, who reports to the Navy Surgeon General. The staffing size and reporting relationships are quite similar to the proposals being considered by the VA for a Medical Inspector in the Department of Medicine and Surgery, except that my office would exercise more external control and influence than apparently exists for any other outside office in the Navy situation.

Air Force.—Quality of care allegations are investigated by the Director of Medical Inspectors of the U.S. Air Force Inspection and Safety Command. While this Command is separate from Air Force Surgeon General operations and appears to be the most independent approach in the three services, we were advised that the investigation staff includes some military doctors assigned on a rotating basis who have or may come under the Surgeon General in prior or future assignments.

Mr. STEINBERG. Have you discussed this situation with the Department of Health and Human Services insofar as any comparable situation might have arisen with respect to the Public Health Service or in its connection with Federal reimbursement programs?

Mr. REYNOLDS. I have had some discussions with the Inspector General at HHS regarding this matter sometime back. Their volume of activity in terms of in-house medical operations as you know is very small compared with VA. Apparently they have not had that much activity or that much effort going in there.

They have, however, had some medical doctors on their staff. I am aware of what those doctors have been working on up to a point at least and that point does not include quality of care issues. They were looking at such things as the adequacy of control over bed utilization but they were not getting directly into patient care issues, at least in the material I had seen at that point in time. It was about a year or so ago that I talked to them.

Mr. STEINBERG. We will obviously be having further discussion on this issue this morning and further communication with you. On a few more issues, do you consider that your IG hotline has been an effective tool to identify areas that merit investigation?

Mr. REYNOLDS. It has been. We have had over 800 hotline calls in volume. We have completed action on 690, I believe. Some of the most important investigations we have done have come out of the hotline.

Mr. STEINBERG. Do you have any kind of scorecard of those 690, that is how many you found to be at least credible allegations?

Mr. REYNOLDS. Yes. In fact, in the back of our annual report is such a scorecard.

Mr. STEINBERG. In your view, it merits the investment of resources made to manage the hotline?

Mr. REYNOLDS. I think it does, but I am disturbed about abuse of the hotline in terms of our obvious vulnerability of people using the hotline to call in and make trouble for somebody. If it's an anonymous allegation, this is where it is going to happen. Yet if the allegation appears to have substance, we don't have a choice but to look into it, but if it doesn't appear to have substance——

Mr. STEINBERG. We found ourselves in the same situation. Are you aware of any incidences where a VA employee has been demot-

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ed, transferred, terminated or otherwise suffered any form of reprisal for making a hotline complaint?

Mr. REYNOLDS. There was one instance where there were indications that that was happening or about to happen. We successfully intervened in that situation and got it stopped and that's the only instance that has come to my attention that I can think of.

Mr. STEINBERG. Agency policy is clear in that regard and you have had the full support of the Administrator and his office and department operating heads to prevent any form of reprisal?

Mr. REYNOLDS. Yes, sir, and my reading of the act is that I am responsible for seeing that it doesn't happen.

Mr. STEINBERG. And you are satisfied in that regard?

Mr. REYNOLDS. Yes, I am.

Mr. STEINBERG. In terms of your audit report recommendations, the GAO indicates in its testimony which you have had an opportunity to review, I believe, that all your recommendations have to be accepted by the operating department or approved by the Administrator or Deputy Administrator and that they result from a process of negotiation after you have made tentative recommendations, or at least they appear to be the result of a negotiated process, rather than being the result of your own independent audit examination and investigation and appraisal of the findings of that process.

Would you comment on the GAO's assertions in that regard, please?

Mr. REYNOLDS. I do not agree with the GAO's evaluation. It is true that we go through a rather thorough staffing process as does the GAO in their reports, and we try to listen to what people have to say and try to understand the disagreements.

I have felt though that we have the opportunity to make things happen rather than just throw out pieces of paper, if in fact we have an unreconciled difference, by taking the disagreement to a decision meeting with the Administrator or Deputy Administrator. Obviously in the process of getting to that stage, we have looked to see whether there are optional ways of accomplishing the same purpose.

If someone says to us, for example, I can't do it in a year, it will take 18 months and they have convincing evidence to that effect, it seems silly to insist on holding to 12 months, putting it in our semiannual report and then telling people later on, well, they didn't follow our recommendation because they didn't do it in 12 months.

I don't consider that a negotiation. It might be viewed as a compromise, but to me it's commonsense. We have not had an occasion to this date when we've gone to the Administrator that we have changed recommendations as a result of meeting with the Administrator.

Mr. STEINBERG. You have not had an instance where—I assume you are including the Deputy Administrator——

Mr. REYNOLDS. That is correct.

Mr. STEINBERG. Where you have taken a recommendation to that level and it has been modified by you after that—so that you stood by your recommendation?

Mr. REYNOLDS. That is correct.

Mr. BUSBEE. The major intent of the recommendation has not been changed.

[Subsequently, the Office of the Inspector General submitted the following information:]

Subsequent to the hearings, we considered further whether there were instances when a recommendation had been changed due to our clearance process. We recall one specific occasion when a recommendation was so modified in a decision meeting. The original recommendation stated "That DM&S reduce television production resources and activities by establishing two national production centers at the St. Louis and Salt Lake City RMEC's."

It was pointed out to us, that although the narrative recognized the possible need for future development of additional production capability, the recommendation as worded placed unrealistic restrictions on future development if required. Since this was never our intent, we agreed to modify the recommendation. It was re-worded and now states "That DM&S reduce television resources and activities by establishing two national production centers at the St. Louis and Salt Lake City RMEC's; and that future increases in any production capability, to be met by establishing additional centers, be fully justified in the budget process." We believe this modification is reasonable and fully warranted.

Mr. REYNOLDS. I can't think of any that have been changed at all. I may be wrong, but I can't think of any offhand that we changed after that discussion. What has happened is that we have not lost, if you will, in taking something through that discussion process. A decision process ordinarily should add 30, at maximum 45 days to issue a report so it's not that extensive.

There was one report where it is true that there was one hung up in that decision process for about a year. But again, I am inclined to feel that our function is not to just issue audit and investigative reports but to see that appropriate actions are taken. I would defend the decision process as a desirable process.

Mr. STEINBERG. How does it compare with the procedures of the other inspectors general?

Mr. REYNOLDS. Generally speaking, they are not going to a decision process at the time they issue their report, they are going to a decision process after they issue the report and that is essentially the procedure OMB calls for.

Mr. STEINBERG. Would you provide a more detailed response on that for the record by talking to the other agencies and finding out? We would ask the GAO if it would, in addition, compare the VA's process in this regard with the other inspectors general in other agencies to determine whether or not they have a similar process before final recommendations are made.

Of course, the question is not only how many recommendations are altered at the Administrator's level, but how many recommendations are altered, revised, or modified prior to that point? The public really has no way of understanding that process, as it would if, for example, you made tentative recommendations and then modified them with an explanation of why they were modified.

It is possible that this policy you are explaining to us, along with the intended establishment of the medical inspector, might be viewed by some as a substantial compromise of your own independence. It is clear you do not view it as such and it is clear GAO has raised serious questions in that regard and we would ask you to evaluate this procedure in terms of whether it is the best way for you to go forward in terms of public confidence and to let us know what the result of that evaluation is.

Is this an ironclad policy that you have that you would not issue a recommendation that is, neither concurred in by the department head, or approved by the Administrator or Deputy Administrator?

Mr. REYNOLDS. No. 1, it is not an ironclad policy and No. 2, I would not put it in those terms because it is not an approval. In other words, I have made a recommendation and the department head has said no, we are not going to implement that recommendation. What I am really asking for is the Administrator or Deputy Administrator to direct implementation of that recommendation. When I call it a decision meeting, that is literally what I am asking for.

Mr. STEINBERG. And you have indicated that in such instances when you have gone to the Administrator or Deputy to request that direction, you have received it?

Mr. REYNOLDS. Yes. You should understand, too, that we are only talking about major findings, significant things that have a significant impact or very sensitive ones.

[Subsequently, the Office of the Inspector General submitted the following information:]

Our decision process on audit recommendations follows the requirements established by GAO in their publication Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, commonly called the GAO audit standards. The decision process begins during the audit when our auditors discuss their findings and recommendations with the audit client. The GAO audit standards state that such discussion should be encouraged in the interests of accuracy of findings and fairness to the audit client.

Discussion of findings and recommendations continues throughout the decision process until our reports are finalized. We send draft reports to the appropriate department or program officials for their written comments. This is recommended by the GAO audit standards which state that one of the most effective ways of ensuring that reports are fair, complete, and objective is through advance comments by officials of the organization discussed in the report. We consider the officials' comments and decide whether these comments warrant our changing the report. If we do not think changes are necessary, we explain in writing why we do not agree with the comments. This procedure also follows the GAO audit standards which state that the auditor should "drop a point or modify a position" if he finds the audit client's argument to be "meritorious." If the arguments are not meritorious, the auditor should state his reasons for rejecting them.

When we reach agreement on recommendations with department officials, we issue a final report. If we cannot reach agreement, but the areas of disagreement are minor, or the issues themselves are minor, we may issue the report at that point noting our disagreement.

If we cannot reach agreement on major issues, then we meet with the Administrator or Deputy Administrator to resolve the issues. This has been necessary in three cases—the audit of DM&S educational television resources, the audit of treatment provided to non-service-connected veteran employees, and our recommendations to strengthen ADP management. In all cases the Administrator or Deputy Administrator agreed with us and ordered the implementation of our recommendations. There have been other instances in which we provided the Administrator with an in-process briefing on certain sensitive audits. These briefings have served, among other things, to overcome potential disagreements from Departments and staff offices.

We think that our decision process is in accordance with the Inspector General Act of 1978, with GAO audit standards, and with accepted audit practice. In this statement, before the Senate Committee on Veterans' Affairs on June 11, 1980, Gregory J. Ahart, Director, Human Resources Division, refers to a report on drug loss and accountability at VA medical centers. This report was a risk analysis report, not an auditor report. One of the purposes of a risk analysis report is to determine the need for an audit. Our risk analysis staff is not part of the Office of Audit, and risk analysis reports are not subject to the same audit standards and processing procedures as audit reports, although it is our policy to maintain the same posture of independence and usefulness.

In conjunction with GAO we contacted appropriate officials in the other 11 Inspector General offices and found that 10 of the other 11 Inspector Generals review agency comments and when agreement to audit recommendations is not reached they perform additional audit work or, when justified, modify or delete sections of the draft report. This decision process may result in a delay in issuing the final report when significant or complex issues are being addressed. A final report is prepared and issued after Inspector General evaluation of agency comments. Recommendations that remain unresolved between agency program personnel and Inspector General staff are referred to higher level agency management for resolution after their final report is issued.

The National Aeronautics and Space Administration and the Veterans' Administration have similar procedures for processing unresolved recommendations. We submit the draft report to program officials for agency comment. My staff reviews and evaluates agency comments and modifies or deletes sections of the draft report when justified. When major recommendations remain unresolved after receiving written comments we take the unresolved recommendations to the Administrator for a decision meeting prior to issuing a final report. The decision process adds approximately 30 days, and a maximum of 45 days, to the issuance of the final report. The report processing systems used by NASA and VA are different from those used by other Inspector Generals in that the final report is not issued without the comments of the agency head (in the small number of cases in which such comments are required). We think that our process is effective because the Administrator addresses audit findings that are significant or complex at the earliest possible time. This process enables us to establish the final agency position before issuing the final report. We would also note that the existence of the process itself tends to put pressure on the Department and staff offices to carefully consider and thoughtfully respond to our draft reports since they must be prepared to defend nonconcurrences to the Administrator.

Only one of our reports, the report on the audit of treatment provided to nonservice-connected veteran employees, was delayed because of our review process. A full and complete review of the issues was justified because of the sensitivity of the audit. Although we had not issued a final report, the findings and recommendations were published in both the April 30, 1979, and the October 31, 1979, Inspector General Semiannual Reports to the Congress.

In his statement Mr. Ahart said: "If the department does not agree with audit report recommendations and the disagreement cannot be resolved between the OA and the department, the report is submitted to the VA Administrator or Deputy Administrator for resolution. If the Administrator approves the recommendation, the report is finalized. *If he does not approve the recommendation, the OA revises or deletes the contested recommendation.*" (Italics added.) This statement is not correct. The situation he mentions has never occurred because the Administrator has never disagreed with one of the our recommendations. Our policy is to publish the final report with the Administrator's comments regardless of whether he agrees with our recommendations. In addition, we have agreed that in the future our reports will indicate when significant recommendations have been changed as a result of the decision process.

Mr. STEINBERG. Finally, Mr. Reynolds, you are aware on May 15, the chairman received an anonymous letter alleging that your office had been engaged in unwarranted harassment of certain VA employees and the fabrication of charges and documents.

On May 27, the committee requested, along with Chairman Roberts of the House Veterans' Affairs Committee, that the GAO investigate those allegations and their testimony this morning reports that they found no substance to them. Were you interviewed in the course of the GAO looking into this matter?

Mr. REYNOLDS. Not in what I would characterize as a direct question and answer interview, no.

Mr. STEINBERG. Were either Mr. Busbee or Mr. Rettew?

Mr. BUSBEE. I was.

Mr. RETTEW. Yes.

Mr. STEINBERG. Do either of the three of you have any knowledge or information that would provide any basis for those allegations?

Mr. REYNOLDS. No, sir, I do not.

Mr. RETTEW. None whatsoever.

Mr. BUSBEE. None whatsoever.

Mr. STEINBERG. And that is what each of you told the GAO?

Mr. BUSBEE. That is right.

Mr. RETTEW. Yes.

Mr. STEINBERG. That concludes the initial questions we have for you and we thank you for your patience. Again, we regret the unusual situation in which the Senate finds itself during this period which has made it difficult for us to have members in continuous presence and we are hopeful they will be able to return.

Mr. Reynolds, we will ask you to return at the end of the hearing to respond to some of the rest of the testimony. Again, we thank you and if, at this point, Mr. Ahart would come forward from the General Accounting Office?

The next witness is Gregory J. Ahart, Director, Human Resources Division, General Accounting Office, accompanied by William Desarno, Supervisory Auditor, Human Resources Division and Harry Johnson, Supervisory Auditor, Human Resources Division.

We welcome you back to the committee and we would again urge that you summarize your testimony so that we will have an opportunity to proceed with some questions. Mr. Ahart?

TESTIMONY OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY GEORGE D. PECK, GROUP DIRECTOR, HUMAN RESOURCES DIVISION; WILLIAM DESARNO, SUPERVISORY AUDITOR, HUMAN RESOURCES DIVISION; AND HARRY JOHNSON, SUPERVISORY AUDITOR

Mr. AHART. Thank you, Mr. Steinberg. I also have with me this morning Mr. George Peck who is also well-known to you.

Mr. STEINBERG. We welcome Mr. Peck and he is well-known to us.

Mr. AHART. We are pleased to be here to discuss certain activities of the VA's Office of Inspector General. We have not made, as you know, a detailed review of the operations of that office. However, we do have some limited observations based on work performed by our task force on fraud and abuse and the results of, first, our review of the Office of Inspector General's investigation of allegations concerning the Palo Alto, Calif., VA Medical Center, which you requested by letter dated January 21, 1980, and second, our inquiry into allegations made against the Office of Inspector General relating to harassment of certain VA employees.

We also have some observations concerning the recently proposed establishment of VA's Office of Medical Inspector which should be of interest to this committee and on which you have had quite a bit of discussion here this morning.

The purpose of our task force on fraud and abuse was to undertake reviews at various Federal agencies, including the VA, to determine first, the extent of identified fraud in these agencies and second, the procedures used to detect and deter fraud.

This work is not yet complete but some of the information from this review will be of interest and we will talk about it here this morning.

In terms of resource allocation to defined objectives, the majority, 56 percent, of staff effort of the Office of Inspector General for fiscal year 1979 was spent performing cyclical audits of VA facilities, programs, or systems and about 31 percent was spent performing special audits and investigations to actively seek out fraud, abuse, waste, and mismanagement.

In the Inspector General's fiscal year 1980 audit plan, we noted two new special initiatives to detect fraud and abuse. Most of the new audits planned are routine cyclical audits of medical centers, regional offices, cemeteries, or audits of ADP systems.

In his April 30, 1980 semiannual report, the Inspector General stated that in comparison with the previous 6-month period, there was a reduction in excess of 50 percent in special initiatives to detect fraud, abuse, and mismanagement because of declining resources.

We recognize that the Office of Inspector General does not have all the staff he thinks he should have but we do believe there needs to be a more concentrated effort maintained to detect fraud and abuse.

Turning to the complaints and allegations that the Inspector General receives, he receives numerous allegations of fraud, abuse, waste, or mismanagement and so on from various sources but he has no formal system in place to account for the total number of allegations received or for the disposition of these allegations.

Without such a system, he does not know the actual number of allegations received, who submitted them or what actions, if any, were taken on them. An additional concern in this connection relates to the referral of allegations deemed to be minor or insignificant by the Office of the Inspector General to various VA departments and offices for action.

Employees probably refer complaints or make allegations to the Inspector General units primarily because attempts to go through normal channels have failed or because they fear reprisal. The practice of the Office of Inspector General of referring certain allegations to the department or offices that may have been the cause for the complaint or allegation without keeping track of its receipt or resolution does not appear to be appropriate.

We believe a system of control over all allegations is necessary and should be adopted by the Office of Inspector General. We understand that such a system is presently being considered.

You had some discussion about the report concurrence procedures and I would like to comment briefly on them. According to our discussions with the Assistant Inspector General for Audit, audit reports are finalized in one of two ways.

Reports dealing with field facilities, except for the Department of Veterans' Benefits, may be finalized by the Office of Audit Field Office Director if the facility director concurs in the recommendations and it is within his power to implement the recommended corrective actions.

All other reports are finalized by the Department of Audit in the Central Office. If the department involved does not agree with the audit report recommendations and the disagreement cannot be resolved between the Office of Audit and the department, the

report is submitted to the VA Administrator or Deputy Administrator for resolution.

If the Administrator approves the recommendation, the report is finalized. If he does not approve the recommendation, the Office of Audit revises or deletes the contested recommendation. In other words, before a report is issued, all audit recommendations have to be accepted and/or approved and all concerned parties have to agree to implement the recommended actions.

We have no problem with discussing report recommendations with management officials and getting their considered reviews, we do it in our own work. We do have problems with reports unduly delayed because of a lack of timely response from affected departments or offices; report recommendations being revised or deleted because of lack of concurrence; and with reports not being issued without concurrence.

It would appear to us that the procedure the Office of Inspector General goes through in attempting to obtain concurrence on recommendations tends to imply that report recommendations are not based on independent and unbiased review but rather on negotiations with all concerned parties.

We believe that after obtaining the department's position, the Inspector General should develop recommendations based on his independent views and go on record with these disclosing any areas of disagreement. I might add that if, based on these negotiations or based on the discussions, the recommendations are changed, the Inspector General should disclose the reasons why they were changed.

Turning to the Palo Alto situation——

Mr. STEINBERG. Mr. Ahart, if I might interrupt, in the course of speaking with Mr. Reynolds, we asked him if he would look at the practices of the other agencies and just so it's on the record in connection with your testimony, we would greatly appreciate it if you would do that in terms of whether there is a variation between what other Inspectors General are doing and what the VA Inspector General is doing in this particular respect.

Mr. AHART. I think we would be happy to do that, Mr. Steinberg, and I suggest that we limit that to sampling of the Inspector Generals rather than going to all of them for comparison purposes.

Mr. STEINBERG. Why don't you let us know what you think would be most comparable and then proceed?

Mr. AHART. We would be glad to do that.

[Subsequently, the General Accounting Office submitted the following information:]

A major effort would have to be undertaken to determine what report procedures are actually being followed by the various OIG's. This would include tracking a number of audits and reports through finalization. This has not been done. We did, however, obtain some limited information primarily through discussions with audit officials of 12 OIG's. Because of the importance of our mission and to insure consistency, these interviews were conducted jointly by staff from the GAO VA audit site and VA's OIG.

The OIG's contacted were at the Departments of Agriculture, Commerce, Energy, Health and Human Services, Housing and Urban Development, Interior, Labor and Transportation. Also, the Community Services Administration, Small Business Administration and the National Aeronautics and Space Administration (NASA). As requested, we attempted to obtain similar information at the Department of Defense (DOD). However, because of the numerous audit organizations and different report-

ing levels at DOD this was not possible in the time allotted. We did however, discuss Army Audit Agency report processing procedures with DOD audit officials.

Based on our limited inquiry, it appears that, with the exception of NASA, all OIG's interviewed handle report processing in a similar manner.

For example, at the conclusion of audit work a draft report containing OIG findings, conclusions and recommendations is submitted to appropriate program officials for comment. Written comments are required in anywhere from 10 to 60 days depending on the individual OIG and/or the sensitivity of the issue. Comments are reviewed and evaluated by the OIG staff and if necessary additional audit work is performed or, if justified, sections of the draft report may be modified or deleted.

If the program officials indicate in their comments on the draft that they do not concur with an OIG recommendation, but the OIG after evaluating those comments, believes the recommendations is still valid, the original recommendation is included in the final issued report followed by the agency's reasons for nonconcurrence and an OIG rebuttal.

Unresolved disagreements on recommendations contained in issued reports may be referred to a higher level in the agency for resolution. Depending on the agency, these higher levels may be the agency director, administrator, secretariat level officers, or an Audit Resolution Board comprised of top agency officials.

The OIG at NASA submits draft reports to program officials for comment. The OIG staff reviews the comments and determines whether the draft findings and recommendations should be retained as originally proposed, modified or deleted. If any recommendations remain unresolved, after the above review the draft report is submitted to the appropriate headquarters program officials for comment. Comments are required within 30 days. If the headquarters office does not concur, the comments are reviewed and the OIG staff again decides whether to retain the recommendation as originally presented, modify it or delete it. If any recommendations remain unresolved after this review the draft report is submitted to the Administrator.

If the Administrator disagrees with the OIG recommendation, NASA's policy is to issue a final report, noting the Administrator's disagreement. Subsequently, the unresolved matter will be reported to Congress in the OIG's semi-annual report.

Mr. AHART. In the chairman's letter of January 21, he asked us to monitor the Inspector General's investigation of allegations made concerning the Palo Alto VA Medical Center. These allegations appeared in a series of newspaper articles in the Peninsula Times Tribune and correspondence from several VA police officers and there has been significant congressional concern in this matter.

The major allegations at the Palo Alto Medical Center include charges of significant increases in the rate of crime, widespread illegal drug use, inadequate support from local and Federal law enforcement agencies, interference by medical center officials in criminal investigations, and reprisals and threats against VA police officers making the allegations.

The Inspector General has prepared a report on its findings. Based on our review of that report and its supporting documentation, we found that most of the major allegations were only pursued in part by the Office of Inspector General. While specific incidents brought to the attention of the Office of Inspector General were addressed, the Office of Inspector General did not attempt to resolve the broader allegations.

Because the report did not reach conclusions for many of the allegations, we attempted to do so based on the report and supporting documents. In our judgment, 8 of the 37 allegations addressed by the Office of Inspector General were sustained, 17 were not, and 12 were unresolved. Of those that were unresolved, we believe further investigation for three of the allegations is warranted, namely the increasing rate of crime at Palo Alto, an alleged $7 million cover-up in the records of the center's supply section, and the harassment of a VA police officer.

In addition, we noted that a number of allegations were not addressed in the Office of Inspector General report or its supporting documentation. We were told that the Office of Inspector General did not address all of the allegations because: One, some were considered not in the purview of the Office of Inspector General, or two, some were not specifically brought to the attention of the Office of Inspector General.

We agree that several were not within the Office of Inspector General's jurisdiction such as the adequacy of other Federal agencies' recent investigations into the allegations at Palo Alto. However, we believe that the Office of Inspector General should have pursued the allegations of reprisals and threats against VA police officers making allegations, inadequate law enforcement support from Federal agencies, VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities and VA police officers being assigned nonsecurity duties.

At the time we prepared our testimony, the Office of Inspector General had not made any recommendations for corrective action. We understand that any recommendations resulting from the Office of Inspector General investigation will be transmitted separately to the Chief Medical Director.

In the chairman's May 27, 1980 letter, he requested that we investigate charges of unwarranted harassment by the Office of Inspector General of certain VA employees and the fabrication of charges and documents. Specifically, the chairman requested that we interview each VA Central Office employee of the Office of Inspector General to determine whether there was any substance to these allegations.

We have interviewed 135 employees of the Office of Inspector General and have not encountered any knowledge of the allegations on the part of the employees nor any documentation to substantiate them. We plan to continue our work on this matter and will report back to the committee shortly.

[Subsequently, the General Accounting Office submitted the following information:]

Mr. Steinberg, I'd like to comment on a comment made by Mr. Reynolds concerning the harassment issue. You asked Mr. Reynolds if he was one of those interviewed by our investigating team. I believe he indicated that he was not. I understand from Mr. Peck that when he received a call from the Committee staff that the request for an inquiry was being made, Mr. Peck discussed the allegations with Mr. Reynolds including the questions of whether he had or was aware of any "enemies" list or if he had directed or had any knowledge of the preparation of any harassment letters. On this basis, we would submit that Mr. Reynolds was included in our inquiry.

Mr. AHART. Turning to the Office of Medical Inspector, the Department of Medicine and Surgery has recently proposed establishing an Office of Medical Inspector. The proposed Medical Inspector will be responsible to the Chief Medical Director for monitoring and reporting on the quality of patient care and other medical determinations.

In fulfilling these responsibilities, the Medical Inspector will conduct special investigations of health-care facilities as requested by the Chief Medical Director; receive, review, and evaluate reports dealing with professional conduct and competency issues; make site

visits to review the quality of care rendered; and, based on information gathered and/or developed, make recommendations to the Chief Medical Director for corrective action.

The Inspector General has been a prime mover in the establishment of this office. In a memo to the Chief Medical Director dated July 11, 1979, the Inspector General stated that his office has been experiencing problems in investigating allegations involving the quality of patient care and related medical matters.

The Inspector General stated that his office lacks the expertise and D.M. & S. lacks the perceived independence because at times doctors who had been assigned to look at quality of care allegations lacked the objectivity or willingness to delve into the facts.

He expressed his concern with one of the existing groups in the Department of Medicine and Surgery and that is the systematic external review program group—SERP—that undertakes reviews which address quality of care and the other D.M. & S. issues. The Inspector General stated that the SERP inquiries have been "uneven in depth and quality."

We understand that the Administrator has not yet approved the establishment of the Office of Medical Inspector. If it is approved, we believe the Office of Inspector General must take measures to assure itself that proper standards and guidelines are developed and rigidly followed by the Office of Medical Inspector in the conduct of its reviews.

If the Inspector General lacks the expertise to adequately review the activities of the Medical Inspector, then he should take steps to obtain under his control and direction the expertise as needed to better insure the integrity of all VA audits and investigations.

In this statement, we have only cited areas of concern relating to the Office of Inspector General operations. We do not mean to imply that the Office of Inspector General has accomplished little since its establishment. We think the reverse is true. Since its establishment, it has increased significantly in staff capability and performed numerous audits and investigations.

Corrective actions have been taken on report recommendations as indicated in the semiannual reports of the Inspector General. We have pointed out some areas of concern without having gone in and taken an overall look and assessed both accomplishments and weaknesses in the overall operations.

That summarizes my statement, Mr. Steinberg, and I will be happy to respond to any questions you might have.

Mr. STEINBERG. Thank you very much, Mr. Ahart.

[The prepared statement of Mr. Gregory J. Ahart and the response of the General Accounting Office to written questions submitted by Hon. Alan Cranston, chairman of the Senate Committee on Veterans' Affairs, follow:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

PREPARED STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

CERTAIN ACTIVITIES OF THE VETERANS ADMINISTRATION'S
OFFICE OF THE INSPECTOR GENERAL

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss certain activities of the Veterans Administration's (VA's) Office of Inspector General (OIG). We have not made a detailed review of the operations of the OIG. However, we do have some limited observations based on work performed by our Task Force on Fraud and Abuse and the results of (1) our review of the OIG's investigation of allegations concerning the Palo Alto, California, VA Medical Center, which you requested by letter dated January 21, 1980, and (2) our inquiry into allegations made against the OIG relating to harassment of certain VA employees and the fabrication of charges and documents, requested in your letter dated May 27, 1980. We also have some observations concerning the recently proposed establishment of VA's Office of Medical Inspector which should be of interest to this Committee.

BACKGROUND

The Inspector General Act of 1978 (Public Law 95-452), enacted on October 12, 1978, established the Office of Inspector General at VA and at eleven other Federal agencies.

By establishing IG offices the Congress intended to create independent and objective units to conduct and supervise audits and investigations of agency programs and operations; provide leadership and coordination and recommend policies to promote economy, efficiency and effectiveness; prevent and detect fraud and abuse; and keep the agency head and the Congress informed about problems with the administration of agency programs, and the necessity for and the progress of corrective action.

The OIG at VA consists of the Office of Audit (OA) and the Office of Investigation (OI), each under the direction of an Assistant Inspector General, and a smaller unit called the Risk Analysis Staff (RAS).

The OA conducts audits of VA programs, functions, activities and organizations and audits or arranges for audits of grants and contracts in accordance with Federal and VA regulations. The OA is authorized a staff of 271, including 235 professionals. The staff is divided fairly evenly among the headquarters planning and programming functions and four field offices located in Atlanta, Chicago, Los Angeles and Hyattsville, Maryland.

The OI conducts administrative investigations covering all activities of VA including individuals and organizations dealing with VA. The OI also conducts proactive investigative surveys to detect fraud and abuse.

The OI is authorized a staff of 72, including 53 professionals. The OI is currently decentralizing which will result in investigators being co-located with auditors in Los Angeles, Chicago, and Atlanta. In addition, an office has been established in New York City and the Washington field office has a suboffice in Puerto Rico.

The RAS assesses the vulnerability of VA's programs, functions and activities relating to fraud, abuse, waste, and mismanagement with a view toward recommending program improvements or areas for future audit and/or investigation. The RAS also reviews proposed legislation and regulations and operates the VA hotline. The RAS is authorized a staff of eight including six professionals.

WORK PERFORMED BY OUR TASK FORCE ON FRAUD AND ABUSE

In September 1978, we issued a report on what Federal agencies were doing to combat fraud in Government programs 1/. Subsequently, we established a Fraud and Abuse Task Force and a toll-free hot-line. The purpose of the task force was to undertake more detailed reviews at various Federal agencies, including VA, to determine (1) the extent of identified fraud in these agencies and (2) the procedures

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1/ "Federal Agencies Can, and Should Do More to Combat Fraud in Government Programs" (GGD-78-62, Sept. 19, 1978.)

used to detect and deter fraud. We expect to issue a report on this review in 1980. The purpose of the GAO hot-line is to permit any individual who has knowledge of or suspects fraud to call that information in to a central point for appropriate disposition.

Some of the information gathered in our review has no bearing on today's hearing. Other information relating to actual audits and investigations undertaken by the agencies reviewed, including VA, is now being processed for computer analyses but will not be available for a few months. We have, however, obtained some limited information from this review concerning the operation of VA's OIG that I believe will be of interest to the Committee.

Activities of the OIG

In terms of resource allocation to defined objectives, the majority (56 percent) of staff effort of the OIG for fiscal year 1979 was spent performing cyclical audits of VA facilities, programs or systems and about 31 percent was spent performing special audits and investigations to actively seek out fraud, abuse, waste and mismanagement. The remainder of staff effort was directed at investigating complaints of significant administrative and/or suspected criminal irregularities; reviewing new legislation, regulations or major systems to identify and correct weaknesses which may affect future integrity, economy, or effectiveness; and performing vulnerability assessments of existing systems and programs.

For example, during the year the OA completed 114 internal audits of various VA facilities, programs or functions, and 77 external audits of contracts, State homes, or State approving agencies. An additional 181 external audits were conducted at the OA's request by other Federal agencies.

The OI completed 71 reactive investigations and 2 proactive surveys in fiscal year 1979. During one proactive OI review about 600 loan guaranty files were reviewed in an attempt to identify fraud in VA's loan guaranty program. The OI also reviewed a number of allegations of wrongdoing and handled complaint mail and security cases.

The RAS completed 3 vulnerability assessments; received, reviewed and processed 650 hotline contacts; and reviewed 77 legislative proposals and 25 VA-proposed regulations.

In fiscal year 1980 the OA plans to complete approximately 41 internal audits carried over from fiscal 1979 and start approximately 150 new audits. The OI plans to continue with reactive investigations and participate in joint efforts with other Federal agencies to identify fraud in specific Federal programs. The RAS plans to complete and issue reports on 12 risk analyses.

In the OIG's fiscal year 1980 audit plan, we noted only two new special initiatives to detect fraud and abuse. Most of the new audits planned by the OIG are routine cyclical audits of medical centers, regional offices, and cemeteries or audits of ADP systems as required by OMB Circular A-71.

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In April 1979 during testimony before the House Veterans Affairs Subcommittee on Special Investigations, we stated that, in view of the size of VA's budget (then in excess of $20 billion), VA programs were inviting targets for fraud and abuse. We said that while VA had detected fraud and abuse, its efforts were limited and sporadic and were not the result of a systematic approach for identifying fraud and abuse. Although VA has identified individual cases of fraud or suspected fraud in all of its major programs, most of these resulted from cyclical audits which are not primarily designed to detect fraud or from activities conducted outside the OIG.

The April 30, 1980, Semi-Annual Report of the OIG states that, in comparison with the previous six months period, there was a reduction in excess of 50 percent in special initiatives to detect fraud, abuse and mismanagement.

According to the IG, the primary reasons for the limited number of audits specifically aimed at detecting fraud were declining resources, added workload, and efforts to audit medical centers on a 3-year cycle. In his May 5, 1980, letter to you, the IG expressed his concern regarding the OIG's ability to conduct audits of medical centers on a 3-year cycle and concluded that a better balance of OIG efforts would be obtained by generally going to a 5-year audit cycle.

While recognizing that the OIG may have a problem with staff resources, we believe that a more concentrated effort must be maintained to detect fraud and abuse.

Control over receipt and disposition of allegations

The OIG receives numerous allegations of fraud, abuse, waste or mismanagement from the VA hotline, complaint mail, department and staff offices in VA, other agencies, and from VA employees who contact auditors or investigators during field work. Presently there is no formal system in place in the OIG to account for the total number of allegations received or for the disposition of such allegations.

For example, if the OI staff determines that an allegation lacks investigative merit, they refer the allegation to the applicable VA department or office. In some cases the referral is made by transmittal memo with a copy retained in the OIG. Oftentimes, however, allegations perceived by the OIG as minor in nature are forwarded without a transmittal memo or any record of OIG receipt, review or referral action.

Without complete information, the OIG does not know the actual number of allegations received, who submitted them or what actions, if any, were taken.

An additional concern we have relates to the referral of allegations deemed to be minor or insignificant by the OIG to the various departments or offices for action. Employees probably refer complaints or make allegations to OIG units primarily because attempts to go through normal channels have failed or because they fear reprisal. The practice of the OIG of referring

certain allegations to the department or offices that may have been the cause for the complaint or allegation without keeping track of its receipt or resolution does not appear to be appropriate.

We believe a system of control over all allegations is necessary and should be adopted by the OIG. We understand that such a system is presently being considered.

Report concurrence procedures

According to the Assistant Inspector General for Audit, reports on reviews made by the OA are finalized in one of two ways depending on the requestor for the audit and subject matter of the report. Generally, reports dealing with field facilities (except the Department of Veterans Benefits (DVB)) may be finalized by the OA field office director if the facility director concurs in the recommendations and it is within his power to implement the recommended corrective actions. In this case the report may be finalized in the field and an information copy of the finalized report is provided to the OIG and appropriate staff at VA Central Office (VACO).

All other audit reports, including those considered sensitive and those specifically requested by the Congress, the Administrator, or others, are finalized by the OA in VACO. The finalization process includes initial review by the facility director, if necessary, and review by the appropriate departmental staff--DVB or Department of Medicine and Surgery (DM&S)--at VACO. If the department does not agree with audit report recommendations and the disagreement cannot be resolved between the OA and the department, the

report is submitted to the VA Administrator or Deputy Administrator for resolution. If the Administrator approves the recommendation, the report is finalized. If he does not approve the recommendation, the OA revises or deletes the contested recommendation. In other words, before a report is issued, all OA recommendations have to be accepted and/or approved and all concerned parties have to agree to implement the recommended actions.

The following example illustrates the concurrence process followed by the OIG and involves a report dealing with controls over drugs at VA medical centers prepared by the RAS.

In May 1980, the RAS staff issued a report on drug loss and accountability at VA medical centers. The study was performed to assess, among other things, controls over drugs as they flowed through the medical centers and prescription costs relating to the fee-basis pharmacy program. To a large extent, the study focused on VA's efforts to convert its ward stock pharmacy systems to unit dose systems.

In a September 1975 report, 1/ we had recommended that VA convert its pharmacy systems to unit dose in order to reduce medication errors and losses and strengthen VA's controls over drugs. As part

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1/"Potentially Dangerous Drugs Missing in VA Hospitals--Different Pharmacy System Needed (Sept. 30, 1975, MWD-75-103)

of a recent followup review on our earlier report, we reviewed a draft of the May 1980 OIG report. At that time the OIG estimated that VA's annual drug losses were a multimillion dollar problem and recommended, among other things, VA implement unit dose pharmacy systems system-wide within the next 5 years. However, as a result of meetings with officials of DM&S, the OIG revised its recommendation and offered several suggested alternative courses of action. The final report notes that the Administrator was briefed on the report, and he had asked DM&S to report on their progress in developing plans for implementing the option of their choice.

An example of a report that went to the Deputy Administrator for resolution was a report relating to VA employees receiving medical treatment for nonservice-connected conditions. This draft report was transmitted to DM&S for comment in April 1979. DM&S responded to the draft in July 1979, indicating a disagreement with the report's recommendations. The draft report was subsequently sent to the Deputy Administrator who concurred in the recommendations in May 1980--about 14 months after the draft report was initially submitted to DM&S for comment.

While we have no problems with discussing report recommendations with management officials and getting their considered views--we do it ourselves--we do have a problem with (1) reports being unduly delayed because of a lack of timely response by affected departments or offices, (2) report recommendations being revised or deleted because of a lack of concurrence, and (3) reports not

being issued without concurrence. As you know, in our reports if the agency disagrees with our conclusions or recommendations, we consider its views in our final report, but do not draw a a recommendation unless after considering the agency's views we are convinced that the recommendation would not be appropriate.

The IG informed us that he follows the procedure of obtaining acceptance or approval of report recommendations because he believes that, if all concur, it is more likely that action will be taken to implement report recommendations.

It would appear that the procedure the OIG goes through in attempting to obtain concurrence on OA or RAS report recommendations tends to imply that report recommendations are not based on independent and unbiased review but rather on negotiations with all concerned parties.

We believe that after obtaining the department's position, the OIG should develop recommendations based on its independent views and go on record with these disclosing any areas of disagreement.

INVESTIGATION OF CERTAIN
ALLEGATIONS INVOLVING THE
VA PALO ALTO MEDICAL CENTER

In your letter of Jaunuary 21, 1980, you asked us to monitor the OIG's investigation of allegations made concerning the Palo Alto VA Medical Center. These allegations appeared in a series of newspaper articles in the Peninsula Times Tribune and correspondence from several VA police officers, and there has been significant congressional concern in this matter.

The major allegations at the Palo Alto Medical Center include charges of:

--significant increases in the rate of crime,

--widespread illegal drug use,

--inadequate support from local and Federal law enforcement agencies,

--interference by medical center officials in criminal investigations, and

--reprisals and threats against VA police officers making the allegations.

In addition, other allegations concerning employee wrongdoing and questionable medical center activities were made during the OIG's on-site investigation which began in December 1979.

The OIG has completed its investigation and has prepared a report of its findings. Based on our review of that report and its supporting documentation, we found that most of the major allegations were only pursued in part by the OIG. While specific incidents brought to the attention of the OIG were addressed, the OIG did not attempt to resolve the broader allegations. One example is the allegation that the crime rate at Palo Alto has been increasing. The OIG collected information indicating that the number of reported crimes had increased; however, the OIG did not attempt to determine the extent to which the increase resulted from more crimes being reported, an increase in patient population, or a real increase in the rate of crime.

In addition, the allegation we considered most serious and certainly the one receiving most of the media coverage--widespread illegal drug use--was only briefly mentioned in the OIG report. Specifically, the allegation was addressed only as it related to two specific incidents at Palo Alto. However, the OIG was aware that the Drug Enforcement Administration (DEA) was also investigating the issue of illegal drug activity at Palo Alto. Following its investigation, the DEA was unable to conclude that any significant or widespread drug activity existed at Palo Alto primarily because the VA police officers who had made the allegations could not provide the DEA investigators any documented evidence to substantiate their allegations. We believe the OIG report should have disclosed the findings and conclusions resulting from the DEA investigation.

Because the OIG report did not reach conclusions for many of the allegations, we attempted to do so based on the report and supporting documents. We designated certain allegations as "sustained" if they were confirmed or corroborated in part or full by the testimony of witnesses and/or documentation. Other allegations were designated "not sustained" if available information indicated that the allegation had no basis in fact. We designated some allegations as "unresolved" if there was not sufficient evidence to make a determination on the veracity of the allegation.

In our judgment, 8 of the 37 allegations addressed by the OIG were sustained, 17 were not, and 12 were unresolved. Of those that were unresolved, we believe further investigation for three of the allegations is warranted, namely

--the increasing rate of crime at Palo Alto;

--an alleged $7 million cover-up in the records of the Center's supply section; and

--the harassment of a VA police officer.

In addition, we noted that a number of allegations were not addressed in the OIG report or its supporting documentation. We were told that the OIG did not address all of the allegations because (1) some were considered not in the purview of the OIG or (2) some were not specifically brought to the attention of the OIG. We agree that several were not within the OIG's jurisdiction such as the adequacy of other Federal agencies' recent investigations into the allegations at Palo Alto. However, we believe that the OIG should have pursued the allegations of reprisals and threats against VA police officers making allegations, inadequate law enforcement support from Federal agencies, VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities, and VA police officers being assigned nonsecurity duties.

At the time we prepared our testimony, the OIG had not made any recommendations for corrective action. We understand that any recommendations resulting from the OIG investigation will be transmitted separately to the Chief Medical Director.

ALLEGATIONS OF HARASSMENT BY THE OIG

Your May 27, 1980, letter requested that we investigate charges of unwarranted harassment by the OIG of certain VA employees and the fabrication of charges and documents. Specifically, you requested

that we interview each VA central office employee of the OIG to determine whether there was any substance to these allegations.

From May 29 to June 6, 1980, we interviewed 135 employees of the OIG. While we perceived a certain amount of employee unrest due to recent reorganizations within the OIG, we have not encountered any knowledge of the allegations on the part of OIG employees nor any documentation to substantiate them. We plan to continue our efforts on this matter and report back to you shortly.

PROPOSED ESTABLISHMENT OF THE OFFICE OF MEDICAL INSPECTOR

DM&S has recently proposed establishing an Office of Medical Inspector (OMI). The proposed OMI will be responsible to the Chief Medical Director for monitoring and reporting on the quality of patient care and other medical determinations. In fulfilling these responsibilities, the OMI will conduct special investigations of health care facilities as requested by the Chief Medical Director; receive, review, and evaluate reports dealing with professional conduct and competency issues; make site visits to review quality of care rendered; and, based on information gathered and/or developed, make recommendations to the Chief Medical Director for corrective action.

The OIG has been a prime mover in the establishment of this office. In a memo to the Chief Medical Director, dated July 11, 1979, the IG stated that his office has been experiencing problems in investigating allegations involving the quality of

patient care and related medical matters. The IG stated that his office lacks the expertise and DM&S lacks the perceived independence because at times doctors who had been assigned to look at quality of care allegations lacked the objectivity or willingness to delve into the facts. The IG has stated that the OIG lacks the "authority" to prevent medical professionals under investigation from using their positions to interfere with testimony of subordinates and using professional and political contacts, including affiliation relationships, to disrupt investigations or implementation of recommendations.

In his memo he also expressed his concern with one of the existing groups in DM&S--the Systematic External Review Program group (SERP)--that undertakes reviews which address quality of care and the other DM&S issues. The IG stated that the SERP inquiries have been "uneven in depth and quality." Moreover, he said that SERP reviews do not seem to go far enough into direct patient care issues. For example, there is no review of patient complaints. Also, he said that SERP reviews follow no rigid standards and review comments are generally based on limited observations and discussions.

In his July 11, 1979, memo, the IG cited the investigation of allegations relating to improper surgical procedures at the Manhattan VA Medical Center. In this investigation, the OIG was criticized for failure to conduct a thorough and objective in-house investigation. Specific criticism of the OIG's investigation included (1) attempts were made to minimize and obscure charges rather than explore them, (2) quality of care issues were not fully explored, and (3) recommended

changes were inadequate. During this investigation, the OIG had referred a number of medical records to DM&S for review. Although this referral is generally a normal procedure when quality of care issues are involved, the OIG and DM&S were criticized for whitewashing the investigation.

Although recognizing problems with independence and the quality of reviews conducted by DM&S either on its own or in assisting the OIG, the IG has nevertheless agreed to the establishment of the OMI. It does not appear that the establishment of another group within DM&S will address the IG's concerns over the objectivity or thoroughness of quality of care inquiries conducted by DM&S.

We understand that the Administrator has not yet approved the establishment of the OMI. If it is approved, we believe that the OIG must take measures to assure itself that proper standards and guidelines are developed and rigidly followed by OMI in the conduct of its reviews. If the OIG lacks the expertise to adequately review the activities of the OMI, then he should take steps to obtain under his control and direction the expertise as needed to better insure the integrity of all VA audits and investigations.

In this statement, we have only cited areas of concern relating to the OIG's operations. We do not mean to imply that the OIG has accomplished little since its establishment. Quite the opposite, when we reviewed VA's internal audit operations in 1977, we pointed out that on a comparative basis with 49 major and minor audit organizations in the Government, VA ranked last in both the ratio of auditors to agency employees and the ratio of auditors to agency appropriations.

Our report 1/ on this matter was instrumental in the Congress adding a significant number of positions to that office. Since the establishment of the OIG, staffing has increased to over 300 authorized positions. Numerous audits and investigations have been undertaken and corrective actions have been taken on report recommendations as evidenced by the OIG's semi-annual reports. I am sure the IG will adequately address the OIG's accomplishments.

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Mr. Chairman, this concludes our statement. We will be happy to respond to any questions you or other Members of the Committee may have.

1/"Greater Audit Coverage of Internal Financial Operations Is Needed" (FGMSD-77-3, Nov. 19, 1976)

RESPONSE OF THE GENERAL ACCOUNTING OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. In your statement you mentioned that the Inspector General was criticized for failure to conduct a thorough and objective investigation at the Manhattan VA Medical Center.

Question 1A. To whose criticism were you referring?

Answer 1A. Congressman Lester L. Wolff (D–N.Y.) has asked GAO to review alleged irregularities involving the Surgical Service at the Veteran's Administration's Manhattan Medical Center. The request stems from the Congressman's dissatisfaction with VA's Office of Inspector General's investigation of certain allegations. In testimony before a joint meeting of the House and Senate Veteran's Affairs Committees, Congressman Wolff said that VA's investigation attempted to minimize and obscure the charges and improprieties rather than explore them, and a further indepth review of the allegations was needed.

Question 1B. (1) Have you evaluated the merits of that criticism? (2) [If yes] What were your conclusions?

Answer 1B. At the present time we are evaluating the work performed by the Office of Inspector General and performing some followup work. It is too early to draw any valid conclusions resulting from our work.

Question 2. Do you believe that the Inspector General's office has made adequate efforts to review the adequacy and validity of DVB quality control procedures, particularly with regard to statistical analyses pertinent to such procedures, in the compensation, pension, insurance, and burial benefits programs?

Answer 2. To date, we have performed no work which would enable us to address VA's Office of the Inspector General's efforts relating to the adequacy and validity of DVB quality control procedures in any of these programs.

Mr. STEINBERG. First let me, on behalf of the committee, thank you very much for your very prompt followup on the May 27 request with respect to the anonymous complaint, and we are relieved to hear your preliminary report on that.

We appreciate your devoting the resources to that matter and your prompt conclusions.

Second, you heard in our earlier discussions with the Inspector General that we asked for them to sit down with you with respect to the 37 Palo Alto allegations and the way you had scored them, shall we say, and see if there is a consensus as to what their findings were in terms of their being substantiated, unsubstantiated, or left in abeyance. If you would cooperate in that, we would appreciate it very much.

You also noted, I am sure, that we have asked for a supplementary report from the Inspector General on Palo Alto in response to a number of the matters you felt were inadequately explored and we will, of course, share that with you when we get it. Hopefully, your discussions with them will yield as much of a consensus as is possible on what further remains to be carried out.

[Subsequently, the General Accounting Office submitted the following information:]

As requested, we did meet with the OIG to discuss our characterization of the 37 Palo Alto allegations in terms of their being sustained, not sustained, or unresolved. We are in the process of preparing a letter report to this Committee containing our analysis of the OIG's investigation at Palo Alto. We will include the OIG's comments in that letter.

Mr. STEINBERG. A final item that you might be of assistance to us with would be to give us a report on the interrelationships that exist within the military departments; that is, within the armed services that we discussed earlier with Mr. Reynolds insofar as their medical inspector general procedure is concerned and whether or not that process is or is not subject to the same kinds of questions you have just raised about the proposed medical inspec-

tor within the Department of Medicine and Surgery. If you would look at that, we would very much appreciate it.

[Subsequently, the General Accounting Office submitted the following information:]

The Department of Defense is exempt from the provisions of Public Law 95–452 which established the Office of the Inspector General at VA and at 11 other Federal agencies. As a consequence, Departmental audits, inquiries, inspections, investigations, et cetera are conducted by several separate and distinct Defense Department organizations. These organizations are the Defense Audit Service, the respective audit agencies (headed by different Auditors General) within the Departments of the Army, Navy, and Air Force, as well as an Inspector General within each of the same three military departments.

Organizationally, the Inspectors General report directly, in the case of the Army and Air Force, to their respective military departments' Chief of Staff and, in the case of the Navy, to the Chief of Naval Operations. The Surgeons General of the Army, Navy, and Air Force are responsible for the direction and supervision of its activities.) The Surgeons General report directly in their respective military departments to the same officers as do the Inspectors General. However, there are significantly different variations in regard to the manner in which each military department's inspector general activity concerning medical-related matters operates.

The Department of the Army Inspector General has worldwide responsibility for inspection of all Army activities including medical. The Army Inspector General's focus is on the health services activity's compliance with Army regulations. In addition in the United States, the Army's Health Service Command performs two kinds of inspections. Teams from the Office of the Inspector General, Health Services Command, visit each Army health-care facility on a scheduled basis to determine the facility's compliance with regulations. In addition, the Health Services Command has a command inspection system under which teams comprised of Health Service Command personnel skilled in operational areas, such as supply and manpower, visit Army health-care facilities. Their focus is on activity management. Overseas the medical commanders perform the same kind of inspection of activities under their command as the Health Service Command performs in the continental United States.

The Bureau of Medicine and Surgery, Department of the Navy has an Inspector General, Medical who inspects all shore-based health service delivery activities on a scheduled basis. These inspections are conducted on behalf of the Surgeon General of the Navy (who commands the Bureau of Medicine and Surgery) to ensure compliance with Navy regulations and efficient operation of all command activities.

Only the Air Force's inspection of medical activities is totally centralized in its Office of the Air Force Inspector General, a headquarters office of the Chief of Staff. This responsibility is fulfilled by the Inspector General's Division of Medical Inspection. Medical representatives in the Inspector General's office are included on inspection teams sent to each base and are responsible for reviewing a health service activity's compliance with Air Force regulations.

The organizational placement of Inspector General responsibilities within the Army's Health Service Command and the Navy's Bureau of Medicine and Surgery is similar to the VA's proposal to establish an Office of Medical Inspector responsible to the Chief Medical Director of the VA's Department of Medicine and Surgery to monitor and report on the quality of patient care and other medical determinations.

Mr. STEINBERG. You suggest in your testimony on page 17, which you just summarized, that you have some questions about the desirability of this arrangement with respect to a medical investigator—a medical inspector responsible to the Chief Medical Director. You say if that is done, you believe the Inspector General must take measures to assure itself that proper standards and guidelines are developed and rigidly followed by that unit in the conduct of its reviews.

Do you have specific measures and criteria that you could share with us now, or is this something you would like to work with them on if they proceed with that?

Mr. AHART. The thought here is the kinds of questions posed during Mr. Reynold's testimony as to how the Inspector General,

which has an overview responsibility with respect to all the operations of the Department, will assure the Administrator and the public that what is being done within D.M. & S., if it should end up being within D.M. & S., is really serving the needs of the Department for an assessment of quality of care and other medical issues which the Inspector General in the past has found that it does not have the expertise to deal with.

We believe that the organization, the Inspector General's organization, needs the competence to see that what is being done is done right. I don't think we would argue that it has to be done by the Inspector General in the first instance, but we would argue that the Inspector General needs the capability to look at it and assure himself and the Administrator, and the Congress and everyone else that what is being done is done right.

We believe to do that, the Inspector General needs some capability under his direction and control that is qualified to provide these assurances.

Mr. STEINBERG. Regardless, you feel the Inspector General must have a continuing medical competency himself?

Mr. AHART. That is correct. I would suspect they would have to have some people in a permanent full-time capacity. They would probably have to call on from time to time people on a contract arrangement, consultant arrangement, to give them some help on that. But without any competence within the Office of Inspector General to deal with medical matters, it is very difficult for us to see how they could provide the assurance and have the capacity to do what is expected of the Office of Inspector General under the Inspector General legislation.

Mr. STEINBERG. In that respect, it would be of service to the committee if you would consult with Mr. Reynolds and Dr. Custis and the Administrator's office as this decisionmaking process goes forward and make your views known and attempt to evaluate whether or not the criteria you just articulated will be met, and keep the committee apprised of what your views are in that regard and any progress in that regard.

I think it would be reassuring to the public for you to be satisfied that whatever process is determined to be established by the VA is one which does meet the requirements of the act and does assure objectivity in that process.

Mr. AHART. We would be happy to do that.

Mr. STEINBERG. Thank you. Would you also be able to consult with other divisions in the General Accounting Office that may be responsible for evaluating Inspector General operations in agencies over which your division does not have jurisdiction to give us some assessment for the record as to whether you believe that, in general, the VA Inspector General is stacking up reasonably well in comparison to other agencies?

Mr. AHART. I think that would be a very difficult undertaking. As I pointed out in my statement, we have not made an overall assessment at this point of VA's Office of Inspector General. We have been into parts of it. I think it's a very difficult comparison to make in any event because of the different kinds of problems and programs which VA has in comparison with other departments and agencies.

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Every agency is unique and each one of them has different kinds of competencies required to look at those programs. I think I want to think about that one a little bit, Mr. Steinberg, and come back and discuss with the committee, after we have had a chance to consult with the other people in GAO with responsibilities in this regard and see if there is anything we might do which would be responsive to your interest but which would be double from the standpoint of what kind of resources would have to be put into it.

Mr. STEINBERG. Certainly, that would be very helpful.

[Subsequently, the General Accounting Office submitted the following information:]

We discussed Mr. Steinberg's request with other GAO divisions responsible for activities of OIG's at various agencies. Because no major reviews have been undertaken of total OIG operations, no valid comparisons of OIG's can be made at this time. However, as part of our responsibilities under Public Law 95–452 we are continuing to look at various aspects of OIG activities. For example, one review being conducted by our Financial and General Management Studies Division is looking at the efforts of various OIG's to resolve outstanding audit findings. Another review being undertaken is looking at the efforts of OIG's to implement the single audit concept under Office of Management and Budget Circular A–102.

These types of reviews may provide a measure of comparison for certain activities of OIG's.

Mr. STEINBERG. What working relationship do you have with the VA's Inspector General Office to avoid duplication of effort, for example?

Mr. AHART. As a matter of general policy with all of the Inspectors General, we try to have a close working relationship and have a good sharing of information. Mr. Peck has the responsibility on behalf of my division to keep in touch with Mr. Reynolds and his people and he could probably speak more directly to the kind of relationship we have.

Mr. STEINBERG. Mr. Peck?

Mr. PECK. What we try to do, if we receive a request or start a job ourselves, is check with the Office of Inspector General to see if they have been in the area or are going into the area. In some cases we have backed off and the Office of Inspector General has gone in and made the inquiry for us.

Mr. STEINBERG. These lines of communication have been open and effective?

Mr. PECK. Yes, we have excellent cooperation.

Mr. STEINBERG. You have been able to avoid duplications through that process?

Mr. PECK. I believe so, yes.

Mr. STEINBERG. Do you consider the IG hotline a valuable investigative resource which should be continued? Is it worth the effort expended?

Mr. AHART. We have not made an overall assessment of that. Mr. Johnson has been working with our fraud and abuse task force and looking at VA activities and he might have some views on the hotline.

Mr. JOHNSON. As Mr. Ahart said, we have not made a detailed evaluation of the hotline. However, we have noted that serious allegations are received which could result in significant findings. Based on the potential I would say yes, the resources are justified.

Mr. AHART. I think as an overall pattern, of course, we run a hotline ourselves within GAO and we have found it quite useful. In

terms of the resource investment it takes to run a hotline, it's not very much. You basically need a telephone and someone who can respond to inquiries, with some publicity so people know where they can call.

I think Mr. Reynolds pointed out that they have had good leads from VA's hotline and we have found within our own organization that it has been worthwhile to us and I think it should be encouraged. I also think most of the Inspectors General operate similar lines. It is not a high cost item and when you get a good lead from it, it has a high payoff.

Mr. STEINBERG. You do not feel it has counterproductive implications insofar as individuals having an opportunity to "make trouble" for other people, as Mr. Reynolds suggested might occur?

Mr. AHART. Certainly when that kind of activity is available, you will get a certain amount of calls that come in from people who are disgruntled for one reason or another and are out to make trouble. Generally, I would expect that most people who do that probably remain anonymous.

They have a lot of things to say and don't want to be identified with it. If they do not remain anonymous, they are probably people who are known within the organization where they work because they probably make trouble not only through a hotline but through other means. I think that is part of the cost you pay if you have that kind of activity. You will get a certain amount of petty nuisance calls but also calls from people seriously wanting to perform a public service.

Mr. STEINBERG. Thank you. Section (4)(b)(1) of the Inspector General Act requires that when carrying out the responsibilities described in subsection (a)(1) of the act which states the Inspector General's duties and responsibilities regarding audit and investigations, that the Inspector General must comply with standards established by the Comptroller General for Audits of Federal programs.

In your opinion, do those standards restrict the Inspector General's jurisdiction in the area of the quality of health care investigations?

Mr. AHART. No, those standards would not.

Mr. STEINBERG. With respect to the Palo Alto situation, you indicate that you reviewed the report of findings and supporting documentation for that investigation. To what extent did you actually monitor the conduct of the investigation?

Mr. AHART. Let me ask Mr. DeSarno to respond to that. He was responsible for that work and we also have Kay Baker from San Francisco as well who was on-site and you might want to ask her to respond to it.

Mr. DESARNO. Let me say a few words first and then I will see if Ms. Baker has any further comments. We had two people from our San Francisco regional office working on this. We had an initial briefing with the Office of Inspector General staff and Office of Inspector General investigator to find out exactly what allegations and other areas they were going to be getting into.

During the course of the Office of Inspector General investigation, we kept in touch with the investigator to find out what he was coming up with. At the time the Office of Inspector General

investigator completed his first draft, we got a copy of it and went over it with him and began reviewing his supporting documentation at that time.

We did not attempt to redirect his investigation in any way but we did keep close tabs on it throughout. Let me ask Ms. Baker if she has anything to add to that.

Ms. BAKER. I don't really have anything to add but I would emphasize that the investigator was very cooperative. He conducted extensive interviews with the individuals involved and also attempted to contact all of the police officers involved. He did run into some difficulties as was earlier discussed in trying to get some of the sources identified and some of the allegations were a little bit sketchy.

Mr. STEINBERG. Do you have specific recommendations for additional followup actions which should be taken at Palo Alto by the Inspector General?

Mr. DESARNO. We believe there are three allegations that warrant further investigation. For the one on the coverup in the supply section, we are suggesting that maybe the Office of Audit should go in and take a look at the accounting records. The allegation on harassment of a VA police officer was briefly addressed in the Inspector General report.

However, we understand from talking to the merit systems protection board that the Board is not looking into the harassment of the police officer involved because they believe it does not constitute an official personnel action. Therefore, the whole issue of harassment concerning the police officer is back within the VA and we believe the Office of Inspector General should look into the harassment charges.

Mr. STEINBERG. Nonsecurity functions?

Mr. DESARNO. Nonsecurity functions would be another area.

Mr. STEINBERG. We have asked, as you know, the Inspector General to followup on those concerns and we will be discussing that with them. You are aware with respect to the possibility of another audit in the supply service—that there was apparently a fairly recent audit in that area that was alluded to. Nevertheless you believe there is sufficient justification for updating that?

Mr. DESARNO. Yes; or at least trying to make another attempt to get to the originator of the allegation.

Mr. STEINBERG. We are hopeful that will be done also.

That concludes our questions. We have obviously given you more paper to go out with than you came in with but we look forward to our continuing relationship with you and your continuing followup on matters we have discussed. Thank you very much.

Mr. AHART. Thank you.

[Subsequently, the General Accounting Office submitted the following information:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

September 26, 1980

HRO-203

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

Your May 27, 1980, letter requested an investigation into allegations that the Veterans Administration's (VA's) Office of Inspector General (OIG) was engaged in the unwarranted harassment of certain VA employees and in the fabrication of charges and documents. You asked that we interview all VA central office OIG employees privately and confidentially to determine whether there was any substance to the allegations. The preliminary results of our investigation were presented in our June 11, 1980, testimony before your Committee.

The allegations concerning OIG harassment of VA employees were made in an anonymous letter to you dated May 15, 1980. The letter charged that VA employees on the "Inspector General's enemies list" were the target of anonymous letters written in the Inspector General's office which contained fabricated charges. In addition, the writer charged that the Inspector General was urging other VA employees to write anonymous letters containing allegations about employees on the "enemies list."

We interviewed each of the 96 OIG central office employees, the 10 Washington Field Office of Investigations employees, and the 53 Eastern Field Office of Audit employees stationed in the Washington, D.C., area to determine whether the allegations had any substance. Each of the employees was asked whether he/she was aware of any

--harassment of VA employees by the Inspector General or his employees,

--"enemies list" maintained by the Inspector General,

--fabricated charges being made against VA employees by the Inspector General or his employees, or

--fabricated charges being made against VA employees by other VA employees at the urging of the Inspector General.

In addition, each employee was asked whether he/she had ever written, or been asked to write, an anonymous letter containing fabricated charges about another VA employee. Secretarial employees were asked whether they were ever asked to type such letters.

None of the OIG central office or field office employees interviewed believed the allegations had any substance. None of them were aware of any harassment of VA employees by OIG employees, of the existence of an "enemies list," of fabricated charges being made against VA employees by OIG employees or by other VA employees at the urging of the Inspector General, or any anonymous letters being prepared by OIG employees. Although we perceived a certain amount of employee unrest because of recent reorganizations within OIG, those employees adversely affected by the reorganizations did not believe the Inspector General was trying to harass them or that they were on any "enemies list."

In summary, we found no evidence to substantiate any of the charges made in the anonymous letter. If you or your staff have any questions regarding the above information, we are available to discuss it with you further.

A similar letter is being sent to the Chairman of the House Committee on Veterans' Affairs who joined you in your request. As arranged with your office, copies will be sent to the Administrator of Veterans Affairs and will be made available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director

Mr. STEINBERG. We will now proceed with our third panel, Dr. Joseph Bailey, associate dean for clinical affairs, Medical College of Georgia; Dr. John A. D. Cooper, president, American Association of Medical Colleges; Dr. Gennaro M. Tisi, associate professor of medicine, University of California at San Diego and chief, pulmonary section, San Diego Veterans' Administration Medical Center.

We will proceed alphabetically if that's agreeable and Dr. Bailey, if you would like to lead off?

TESTIMONY OF A PANEL CONSISTING OF DR. JOSEPH P. BAILEY, JR., ASSOCIATE DEAN FOR CLINICAL SCIENCES, PROFESSOR OF MEDICINE, MEDICAL COLLEGE OF GEORGIA, AUGUSTA, GA.; DR. JOHN A. D. COOPER, PRESIDENT, AMERICAN ASSOCIATION OF MEDICAL COLLEGES; AND DR. GENNARO M. TISI, ASSOCIATE PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA AT SAN DIEGO AND CHIEF, PULMONARY SECTION, SAN DIEGO VETERANS' ADMINISTRATION MEDICAL CENTER

Dr. BAILEY. Thank you. Mr. Chairman, members of the committee, I am Dr. Joseph P. Bailey, professor of medicine and associate dean for clinical sciences of the Medical College of Georgia at Augusta. I testify as an official spokesman for the school whose dean, Dr. Fairfield Goodale, would have been here in my stead today had it not been for a long-standing prior commitment. Our medical school is closely associated with the Augusta VA Medical Center.

I am pleased to have the opportunity to testify before the Senate Veterans' Affairs Committee concerning the difficulties that our school has experienced with the program of the Inspector General within the VA. Obviously, a program of inspection is necessary in any agency of Government in order to provide the appropriate accountability to the American taxpayers.

However, it is one thing for the Office of the Inspector General of the VA to explore matters of the administrative effectiveness and efficiency of the agency but quite another to investigate questions dealing with the clinical operations of the Department of Medicine and Surgery.

The school of medicine with which the VA Medical Center in Augusta, Ga., is affiliated has had firsthand contact with the heavy-handed operations of the Inspector General.

Stemming from an issue of the propriety of contracting with a pacemaker surveillance company from Gainesville, Fla., the Inspector General investigated programs involving implantation of permanent pacemakers in veterans and the postoperative surveillance of the continued effectiveness of these implanted pacemakers.

This specific investigation raised questions of whether the surgeons responsible for the implantation of pacemakers as well as the continued followup surveillance of these pacemakers were in a conflict-of-interest situation. In the Augusta case, the cardiovascular surgeons involved in the implantation of and followup on, pacemakers hold appointments at both the VA medical center and the School of Medicine of the Medical College of Georgia.

Two of these individuals hold part-time appointments at both institutions and the third serves as a consultant to the VA medical

center. It appeared impossible for the inspectors to comprehend the intricacies of what it meant for a surgeon to be part time at both institutions and to understand that the surgeons see themselves as engaged in one and only one professional activity, the care of patients, both veterans and nonveterans, at the VA medical center and the Talmadge Memorial Hospital, the major teaching hospital for the veterans center.

For the provision of the professional services, they receive a check for the portion carried out at the VA medical center from the VA and another from the State of Georgia for that carried out at the Talmadge Memorial Hospital. The inspectors also appeared to have been unable to grasp the fact that once the surgeon had worked the required number of hours at the VA, what he chose to do with the remainder of his time was of no concern to the VA and that to work for the State of Georgia constituted no conflict of interest for that individual.

In fact, these inspectors appeared to have no comprehension of the arrangements under which physicians have worked for the Department of Medicine and Surgery of the VA since the late 1940's. The practice under which physicians hold part-time appointments at the VA medical center and at the medical school is not of recent origin but has been standard procedure since Gen. Omar Bradley served as Administrator of Veterans' Affairs.

It is of further interest that the inspectors, after accusing the surgeons involved of a variety of improprieties during their interviews with them, never followed up to indicate to the accused individuals that the case was closed without any adverse findings of impropriety on the part of those individuals.

In fact, a letter exonerating those alleged of misconduct was forthcoming from the VA only after the surgeon invited to provide testimony to an oversight subcommittee of the Senate Committee on Veterans' Affairs refused to appear until such a letter had been issued.

It is this unfeeling, uncaring and high-handed approach to physicians in areas about which it is obvious that the inspectors have no knowledge that may lead to the destruction of the close working relationships that have been fostered between the individual VA medical centers and affiliated schools of medicine.

From our experience, perhaps limited, it was clear that individuals employed as inspectors in the Office of Inspector General of the VA have no understanding whatsoever of the carefully crafted mechanisms developed by successive Administrators of Veterans' Affairs and Chief Medical Directors to create and maintain the affiliation program.

Their callous intrusion into a well-working system is destructive and uncalled for. We at the School of Medicine of the Medical College of Georgia believe that if an Inspector General program is necessary from the point of view of the Department of Medicine and Surgery, this function would be best carried out by a medical inspector general directly under the supervision of the Chief Medical Director and with no connection to the Inspector General of the VA.

Under such a system, physicians with an intimate knowledge of the affiliated programs that have been developed over the years

between the VA and the schools of medicine would be involved in issues that deal directly with title 38 personnel as well as with clinical problems. These are two areas about which the inspectors currently employed by the Inspector General appear to have neither knowledge nor the ability to understand.

Based on our experience in Augusta, we are concerned that the inspection procedures employed by the Inspector General of the VA will have continued divisive effects upon the affiliation program. This can only result in compromising the high standards of care currently enjoyed by veteran patients in VA medical centers affiliated with schools of medicine.

We believe that without affiliation, it would be extremely difficult for these VA medical centers to obtain the talents of the outstanding and highly skilled physicians currently on their staff, either on a full-time or part-time basis.

Should the affiliations terminate, most if not all of these physicians would leave the VA. We believe that the high quality of care currently provided veterans in affiliated VA medical centers would no longer exist should the affiliation program be jeopardized.

We further believe that the program is in jeopardy at this time due, among other things, to the inappropriate activities of the Inspector General's office as far as clinical matters and title 38 personnel are concerned.

Many thanks for this opportunity to tell the committee about our experience at the Medical College of Georgia. I would be pleased to try to answer any questions you have.

Mr. STEINBERG. We will withhold questions until we have received all of the testimony from the panel, but we thank you, Dr. Bailey, for your testimony and for coming to be with us today.

[The prepared statement of Dr. Joseph P. Bailey, Jr., and other related materials follow:]

PREPARED STATEMENT OF DR. JOSEPH P. BAILEY, JR., ASSOCIATE DEAN, CLINICAL SCIENCES, PROFESSOR OF MEDICINE, MEDICAL COLLEGE OF GEORGIA, AUGUSTA, GA.

Mr. Chairman and Members of the Committee,

I am Dr. Joseph P. Bailey, Professor of Medicine and Associate Dean for Clinical Sciences of the Medical College of Georgia, at Augusta. I testify as an official spokesman for the school whose dean, Dr. Fairfield Goodale would have been here in my stead today, had it not been for a long standing prior commitment. Our medical school is closely associated with the Augusta VA Medical Center.

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programs involving implantation of permanent pacemakers in veterans, and the post operative surveillance of the continued effectiveness of these implanted pacemakers. This specific investigation raised questions of whether the surgeons responsible for the implantation of pacemakers as well as the continued follow-up surveillance of these pacemakers were in a conflict of interest situation. In the Augusta case, the cardiovascular surgeons involved in the implantation of and follow-up on, pacemakers hold appointments at both the VA Medical Center and the School of Medicine of the Medical College of Georgia. Two of these individuals hold part time appointments at both institutions and the third serves as a Consultant to the VA Medical Center. It appeared impossible for the Inspectors to comprehend the intricacies of what it meant for a surgeon to be part time at both institutions and to understand that the surgeons see themselves as engaged in one and only one professional activity: the care of patients---both veterans and non veterans---at the VA Medical Center and the Talmadge Memorial Hospital. For the provision of the professional services, they receive a check for the portion carried out at the VA medical center from the VA and another from the state of Georgia for that carried out at the Talmadge Memorial Hospital. The inspectors also appeared to have been unable to grasp the fact that, once the surgeon had worked the required number of hours at the VA, what he chose to do with the remainder of his time was of no concern of the VA and that to work for the State of Georgia constituted no conflict of interest for that individual. In fact, these inspectors appeared to have no comprehension of the arrangements

under which physicians have worked for the Department of Medicine and Surgery of the VA since the late 1940's. The practice under which physicians hold part time appointments at the VA Medical Center and at the medical school is not of recent origin but has been standard procedure since General Omar Bradley served as Administrator of Veterans Affairs.

It is of further interest that the inspectors, after accusing the surgeons involved of a variety of improprieties during their interviews with them, never followed up to indicate to the accused individuals that the case was closed without any adverse findings of impropriety on the part of those individuals. In fact, a letter exonerating those alledged of misconduct was forthcoming from the VA only after the surgeon invited to provide testimony to an oversight Subcommittee of the Senate Committee on Veterans Affairs refused to appear until such a letter had been issued.

It is this unfeeling, uncaring, and high-handed approach to physicians in areas about which it is obvious that the inspectors have no knowledge that may lead to the destruction of the close working relationships that have been fostered between the individual VA Medical Centers and affiliated Schools of Medicine. From our experience, perhaps limited, it was clear that individuals employed as inspectors in the Office of the Inspector General of the VA have no understanding whatsoever of the carefully crafted mechanisms developed by successive Administrators of Veterans Affairs and Chief Medical Directors to create and maintain the affiliation program. Their callous intrusion into a well working system is destructive and uncalled for. We at the School of Medicine of the Medical College of Georgia believe that, if an Inspector General program is

necessary from the point of view of the Department of Medicine and Surgery, this function would be best carried out by a Medical Inspector General directly under the supervision of the Chief Medical Director and with no connection to the Inspector General of the VA. Under such a system, physicians with an intimate knowledge of the affiliated programs that have been developed over the years between the VA and the Schools of Medicine would be involved in issues that deal directly with Title 38 personnel as well as with clinical problems. These are two areas about which the inspectors currently employed by the Inspector General appear to have neither knowledge nor the ability to understand.

Based on our experience in Augusta, we are concerned that the inspection procedures employed by the Inspector General of the VA will have continued devisive effects upon the affiliation program. This can only result in compromising the high standards of care currently enjoyed by veteran patients in VA Medical Centers affiliated with Schools of Medicine. We believe that, without affiliation, it would be extremely difficult for these VA Medical Centers to obtain the talents of the outstanding and highly skilled physicians currently on their staff, either on a full time or part time basis. Should the affiliations terminate, most if not all of these physicians would leave the VA. We believe that the high quality of care currently provided veterans in affiliated VA Medical Centers would no longer exist should the affiliation program be jeopardized. We further believe that the program is in jeopardy at this time due, among other things, to the inappropriate activities of the Inspector General's office as far as clinical matters and Title 38 personnel are concerned.

Many thanks for this opportunityto tell the Committee about our experience at the Medical College of Georgia. I would be pleased to try to answer any questions you have.

Mr. STEINBERG. Dr. Cooper, I might mention before you start to those in attendance today that there are empty seats in front of the room if those standing wish to take them.

Dr. COOPER. Mr. Steinberg, we also appreciate the opportunity to testify on the activities of the Office of Inspector General of the Veterans' Administration. Our interest, of course, stems from the highly productive relationships that have been developed between the country's medical schools and the Veterans' Administration hospitals since the end of World War II.

Affiliation agreements encompassing patient care, medical education, and research are now in force between 104 medical schools and 136 out of the existing 172 VA hospitals. There is no question that this partnership has served the national interest well.

The academic atmosphere created in the VA hospitals by the close affiliations with schools of medicine has enabled the VA to recruit and retain physicians of unusual talent and competence in these affiliated institutions. The end result has been a substantial improvement in the quality of medical care provided to former servicemen and the emergence of vigorous and productive research programs that have contributed greatly to advancement in the health of both veterans and the general population.

The association strongly supports the elimination of fraud, abuse, waste, and mismanagement in Government operated and sponsored programs. Responsible stewardship of Federal funds is especially needed at a time when budgetary concerns are forcing reductions in many significant Federal social programs. At the same time, the AAMC would hope that the Federal Government could fulfill its statutory obligations in a manner so as to avoid any unwarranted intrusion into medical practice and research and deterioration in the valuable relationships between VA hospitals and academic medical centers.

The issue most frequently drawn to the attention of the AAMC has concerned the style of behavior demonstrated by field investigators from the Office of the Inspector General. It is essential that in carrying out an audit or investigation at a VA hospital, the staff of the Inspector General demonstrates sensitivity both to the rights of the subjects of investigations and to the unique nature of medical practice.

The rights of individuals under investigation must be respected. Professional reputation is among the most important assets a physician has. The manner in which an investigation is conducted may cast a cloud over an individual that is difficult to dispel even after the subject is exonerated of any wrongdoing.

Medical staff should be permitted to have counsel present during an interrogation by a member of the Inspector General's staff and they should be made aware of their right to have such counsel present.

Individuals interviewed during the course of an investigation should be permitted access to any report or notes on the interview in order to verify that the investigator properly interpreted statements made by them. Furthermore, at the earliest possible time, consistent with a properly conducted investigation, the subject of the inquiry should be informed of the nature of any allegations against him. The association understands that up to a point, secre-

cy is important to the successful completion of an investigation. However, the need for secrecy must be weighed against the detrimental impact upon VA personnel of the uncertainty and apprehension caused by an ongoing inquiry of an unknown nature and efforts should be made to keep any negative effects at a minimum.

Similarly, in auditing the attendance of part-time physicians, a full understanding of the nature of medical practice is necessary. In developing general regulations related to part-time employment, both the Office of Personnel Management and the VA are dealing with large numbers of civil servants performing a wide variety of services and functions in a huge Federal bureaucracy. Thus the rules established by these agencies may not be appropriate for the small group of part-time physicians who cannot so easily predict in advance the exact time period at which their services will be most needed or during which they will be able to be present at a VA facility. Part-time physicians at the VA typically have responsibilities at other affiliated hospitals within an academic medical center. Medical emergencies and other unforeseen obligations at these other institutions may require them to depart from any prearranged schedule at the VA. The association is pleased to note from the Inspector General's most recent report that that office is aware of this problem and that an attempt is being made to develop rules taking into account these particular circumstances.

Another matter that has come to the AAMC's attention on several occasions relates to Inspector General investigators extending the reach of their inquiries to matters beyond their authority and especially their competence.

The VA Inspector General has been given fairly extensive authority under the Inspector General Act of 1978 (Public Law 95-452). However, there are some limitations upon his jurisdiction. As stated in the report of the Senate Governmental Affairs Committee that accompanied the act:

> Broad as it is, the Inspector and Auditor General's mandate is not unlimited. Issues requiring substantive or technical expertise will often fall outside his proper sphere.

The AAMC respectfully submits that questions relating to medical practice fall within this category of issues. The peer review system is a long tradition in medicine and one that we believe has been inadequately observed in the Office of Medicine of the Veterans' Administration. Thus, any investigation into the adequacy or appropriateness of health services should be performed by persons with a background in medicine. The association recommends that a separate Office of Medical Inspector be established for this purpose.

We were pleased to note from the testimony of the Inspector General that steps have been taken toward the establishment of such an office, but we are very disappointed in the criticisms that have been directed against this approach by the GAO and some of the members of the committee.

We think the chief medical director and the physicians working in the Veterans' Administration have at least as great a concern about the quality of care as does the Inspector General, the GAO, or this committee. We think that given the resources available to the Chief Medical Director, he has done an excellent job in assuming the adequacy of the service provided VA patients.

We have continually testified before committees of the Congress that the health professional staffing of VA facilities for carrying out their responsibilities is insufficient. The patient/staff ratio at VA facilities is even below the staffing ratio of some of our community hospitals, in spite of the fact that the VA handles much more complex patients that require a higher intensity of care than most patients in community hospitals. Many of the criticisms that have been leveled by the Inspector General relate to inadequate documentation of the medical service provided. We think many of these problems could be ameliorated by more adequate staffing.

This problem could also be addressed by installation of a modern medical information system at VA institutions. Although proposals have been made on a number of occasions to provide this important management tool, funds have not been available to implement the program.

We urge that Congress support this development by appropriation of funds required and that it impress upon the administration, particularly the Office of Management and Budget, the importance of moving ahead rapidly to install such systems which we think will correct many of the problems now besetting the Veterans' Administration Medical Department in carrying out its role.

Again, I would like to say that we believe that review of the professional performance of the physician should be undertaken only by individuals who possess the training and expertise necessary to evaluate the quality of medical care. The recently filed third semiannual report of the Inspector General elaborates upon the background of its professional staff.

The members of its audit and investigation staff are primarily accountants, management analysts, and individuals with experience in investigating white-collar crimes. There is no indication that any of the staff of the Inspector General has medical or other qualifications that would enable them to intelligently perform an adequate investigation of professional activity related to the provision of health care. That is why we were so enthusiastic about having an Office of Inspector General established with the medical department of the VA which, of course, could be supervised with regard to the processes which they use in carrying out their functions by the Inspector General as part of his overall function in the department.

The Inspector General has been critical of the level of utilization of certain specialized medical programs at VA hospitals—cardiac catheterization labs, electron microscopy labs, and renal dialysis units. The association appreciates the need to assure that limited Federal resources are used effectively. However, for those VA hospitals that are affiliated with academic medical centers, the question of degree of utilization must be viewed from the perspective of institutions with multiple purposes, including undergraduate and graduate medical education, research and research training and health care. Thus, the peculiar needs of training facilities must be taken into consideration. In this regard, the significance of these additional functions in helping to maintain the quality of health services at VA hospitals should not be minimized.

In those instances when educational imperatives require the existence of specialized programs that may not be fully utilized, the

sharing of services with other Federal and private institutions is the most desirable means of addressing the problem of underutilization. However, longstanding roadblocks to sharing clinical services still need to be overcome. This is an issue that the committee may wish to look into in greater depth.

In conclusion, I think the association believes that an improved understanding on the part of the Office of the Inspector General of the needs and obligations of medical practitioners and of teaching hospitals can help to eliminate any unnecessary friction between the staffs of that office and the VA and to maintain the productive relationships between the VA hospitals and the medical schools. The association appreciates this opportunity to submit its views concerning the activities of the VA Inspector General.

Mr. STEINBERG. Dr. Cooper, we thank you for your testimony and we will withhold questions until after Dr. Tisi testifies.

[The prepared statement of Dr. John A. D. Cooper and his response to written questions submitted by Hon. Alan Cranston, chairman of the Senate Committee on Veterans' Affairs follow:]

68-178 O—80——10

aamc association of american medical colleges

PREPARED STATEMENT OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) appreciates this opportunity to testify about medical school related activities of the Office of the Inspector General of the Veterans' Administration. The Association serves as the national voice for all of the 126 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and over 60 academic and professional societies whose members are engaged in teaching, in patient care and biomedical research.

The Association's interest in the activities of the Inspector General stems from the highly productive relationships that have developed between the country's medical schools and the Veterans' Administration hospitals since the end of World War II. Affiliation agreements encompassing patient care, medical education and research are now in force between 104 medical schools and 136 out of the existing 172 VA hospitals. There is no question that this partnership has served the national interest well. The academic atmosphere created in the VA

hospitals by the close affiliations with schools of medicine has enabled the VA to recruit and retain physicians of unusual talent and competence in these affiliated institutions. The end result has been a substantial improvement in the quality of medical care provided for former servicemen and the emergence of vigorous and productive research programs that have contributed greatly to advancement in the health of both veterans and the general population.

The Association strongly supports the elimination of fraud, abuse, waste and mismanagement in government-operated and sponsored programs. Responsible stewardship of Federal funds is especially needed at a time when budgetary concerns are forcing reductions in many significant Federal social programs. At the same time, the AAMC would hope that the Federal government could fulfill its statutory obligations in a manner so as to avoid causing any unnecessary deterioration in the valuable relationships between VA hospitals and academic medical centers.

Performance of Investigations by the Staff of the Inspector General

The issue most frequently drawn to the attention of the AAMC has concerned the style of behavior demonstrated by field investigators from the Office of the Inspector General. It is essential that, in carrying out an audit or investigation at a VA hospital, the staff of the Inspector General demonstrate sensitivity both to the rights of the subjects of investigations and to the unique nature of medical practice.

The rights of individuals under investigation must be respected. Professional reputation is among the most important assets a physician has. The manner in which an investigation is conducted may cast a cloud over an individual that is difficult to dispel even after the subject is exonerated of any wrongdoing. Medical staff should be permitted to have counsel present during an interrogation by a member of the Inspector General's staff. Individuals interviewed during the course of an investigation should be permitted access to any report or notes on the interview in order to verify that the investigator properly interpreted statements made by them. Furthermore, at the earliest possible time, consistent with a properly conducted investigation, the subject of the inquiry should be informed of the nature of any allegations against him. The Association understands that, up to a point, secrecy is important to the successful completion of an investigation. However, the need for secrecy must be weighed against the detrimental impact upon VA personnel of the uncertainty and apprehension caused by an ongoing inquiry of an unknown nature, and efforts should be made to keep any negative effects at a minimum.

Similarly, in auditing the attendance of part-time physicians, a full understanding of the nature of medical practice is necessary. In developing general regulations related to part-time employment, both the Office of Personnel Management and the VA are dealing with large numbers of civil servants performing a wide variety of services and functions in a huge Federal bureaucracy.

Thus, the rules established by these agencies may not be appropriate for the small group of part-time physicians who cannot so easily predict in advance the exact time period at which their services will be most needed or during which they will be able to be present at a VA facility. Part-time physicians at the VA typically have responsibilities at other affiliated institutions; medical emergencies and other unforeseen obligations at these other hospitals may require them to depart from any pre-arranged schedule at the VA. The Association is pleased to note from the Inspectors General's most recent report that that Office is aware of this problem and that an attempt is being made to develop rules taking into account these particular circumstances.

Qualifications of the Staff of the Inspector General

Another matter that has come to the AAMC's attention on several occasions relates to Inspector General investigators extending the reach of their inquiries to matters beyond their authority and especially their competence.

The VA Inspector General has been given fairly extensive authority under the Inspector General Act of 1978 (P.L. 95-452). However, there are some limitations upon his jurisdiction. As stated in the Report of the Senate Governmental Affairs Committee that accompanied the Act: "Broad as it is, the Inspector and Auditor General's mandate is not unlimited. Issues requiring substantive or technical expertise will often fall outside his proper sphere." The AAMC respectfully submits that questions relating to medical practice fall within this category of

issues. Any investigation into the adequacy or appropriateness of health services should be performed by persons with a background in medicine. The Association recommends that a separate Office of Medical Inspector be established for this purpose.

The AAMC believes it imperative that any review of the professional performance of physicians be undertaken only by individuals who possess the training and expertise necessary to evaluate the quality of medical care. The recently filed third Semi-Annual Report of the Inspector General elaborates upon the background of its professional staff. The members of its audit and investigation staff are primarily accountants, management analysts and individuals with experience in investigating white collar crime. There is no indication that any of the staff of the Inspector General has medical or other qualifications that would enable them to intelligently perform an adequate investigation of professional activity related to the provision of health care.

Underutilization of Specialized Medical Programs

The Inspector General has been critical of the level of utilization of certain specialized medical programs at VA hospitals---cardiac catheterization labs, electron microscopy labs and renal dialysis units. The Association appreciates the need to assure that limited Federal resources are used effectively. However, for those VA hospitals that are affiliated

with academic medical centers the question of degree of utilization must be viewed from the perspective of institutions with multiple purposes---including undergraduate and graduate medical education; research and research training; and health care. Thus the peculiar needs of training facilities must be taken into consideration. In this regard, the significance of these additional functions in helping to maintain the quality of health services at VA hospitals should not be minimized.

In those instances when educational imperatives require the existence of specialized programs that may not be fully utilized, the sharing of services with other Federal and private institutions is the most desirable means of addressing the problem of underutilization. However, long standing roadblocks to sharing clinical services still need to be overcome. This is an issue that the Committee may wish to look into in greater depth.

Importance of a Modern Medical Information System

Many of the criticisms leveled by the Inspector General's investigations center around lack of adequate documentation of the medical services provided. The problems could be ameliorated by the development and installation of a modern medical information system at VA institutions. Although proposals have been made to provide this important management tool, funds have not been available to implement the program. We urge that the Congress support this development by appropriations of the funds required and impress upon the Administration,

particularly the Office of Management and Budget, the importance of moving ahead rapidly to install such systems.

Conclusion

The Association believes that an improved understanding on the part of the Office of the Inspector General of the needs and obligations of medical practitioners and of teaching hospitals can help to eliminate any unnecessary friction between the staffs of that Office and the VA and to maintain the productive relationships between the VA hospitals and the medical schools. The Association appreciates this opportunity to submit its views concerning the activities of the VA Inspector General.

RESPONSE OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS AFFAIRS

Question 1. Please provide a description of what, in your opinion, would be a workable system for keeping track of part-time physician attendants while providing the flexibility necessary to meet the needs of such a physician's schedule?

Answer. The Association has been informed that the VA's Chief Medical Director and Inspector General, together with the General Accounting Office, have been examining this question and have developed a new policy that has not yet been formally approved. Under the proposed rules, the Association understands that 25 percent of the hours worked in a pay period by part-time physicians would be unmodifiably assigned and that the physicians would be required to keep a record, to be reviewed and approved by their supervisors, for the remaining hours worked. It is the AAMC's belief that this arrangement would represent a reasonable accommodation of two separate concerns: The need to recognize the special character of the practice of medicine, especially for doctors affiliated with several hospitals; and the need for accountability on the part of Government employees. If once this procedure has been initiated, problems emerge, I will, of course, apprise your Committee of any suggestions the Association may have for constructive modifications of the system.

Question 2A. Do you believe that the VA has made adequate efforts to inform affiliated medical schools of the purpose of IG investigations and of the importance of the IG mission?

Answer. The Association is of the view that the true problem does not lie with the failure of the affiliated medical schools to properly comprehend the necessity and purpose of IG investigations; rather, the AAMC strongly believes that the real issue is a lack of understanding demonstrated by the IG staff of the nature of medical practice in general and the VA's affiliation agreements with medical schools in particular. The general demeanor and attitude of the Inspector General's staff that appear to characterize these investigations is probably, from the perspective of the VA's physician staff, the most troublesome aspect of the investigative process. As I noted in my testimony before the Committee, professional reputation is extremely important to a physician's career. An inappropriately conducted investigation may permanently damage an individual's reputation even after that physician has been cleared of any wrongdoing. Thus, such investigations must be conducted with real sensitivity for the professional name of subjects of the investigation and with full understanding of the unique nature of medical practice.

Question 2B. Do you believe that greater efforts in this area would help alleviate medical schools' apparent resentment of IG investigations?

Answer. Again, the AAMC is of the opinion that lack of information is not the cause of resentment on the part of the medical schools with regard to these investigations. However, the Association believes that greater efforts by the Office of the Inspector General to understand the points outlined in answer to part A of this question would prove useful in ameliorating these difficulties.

As indicated in the Association's testimony, the AAMC is firmly convinced that much of this problem could be alleviated if investigations into the appropriateness or adequacy of health care were performed by individuals who possess the training and expertise necessary to properly evaluate medical care. The recently filed third Semi-Annual Report of the Inspector General discusses the background of its professional staff. The members of its audits and investigation staff are primarily accountants, management analysts and individuals with experience in investigating white collar crime. There is no indication that the staff possesses the requisite qualifications that would permit them to adequately investigate professional activity related to the provision of health care. Thus, the Association strongly recommends that a separate Office of Medical Inspector be established for this purpose.

Finally, it would be useful to supply physicians on the staffs of VA hospitals with more information about the IG. It is particularly important that a clear statement of the rights of personnel interrogated during these investigations be made available. Such a statement should include: Right to have counsel present during interrogation; and access to interview notes and reports to verify that the investigator has properly interpreted statements. Moreover, it should be understood that the subject of an inquiry should be notified of the nature of the allegations against him at the earliest possible time.

Mr. STEINBERG. Dr. Tisi, we welcome you and appreciate very much your coming all the way from California. I know Senator Cranston wanted to be here for your testimony and regrets that other Senate business has prevented him from doing so, but he will certainly be reviewing all of the testimony very carefully and with particular reference to yours.

Would you please proceed?

Dr. TISI. Thank you very much. Mr. Chairman, thank you for the opportunity to describe the actions and comportment of the Inspector General's Office at the San Diego Veterans Medical Center during the 8-day period from May 1–8, 1980.

During this time, a single representative of the IGO succeeded in (1) interfering and interrupting patient care, (2) violating my civil rights and those of my staff, and (3) denying a reasonable interpretation of a university-VA affiliation agreement. A summary of each of these three points is enclosed in appendix I of my letter to Senator Cranston dated June 2, 1980. I would like to stress two of these areas, that is, (1) interference with and interruption of patient care, and (2) denial of a university-VA affiliation.

First, with reference to interruption of and interference with patient care, the primary mission of our hospital is patient care and as such, our hospital deals in a service and not a product. Fortunately, no VA patient was irreversibly affected by the interference and interruption by the IGO of the patient care activities of the pulmonary section. Patients were inconvenienced to be sure and their evaluations were delayed but none died.

The point is that such a catastrophe could have occurred and is a likely probability when non-health-care professionals are turned loose on a health-care facility and place their perception of administration processes above patient care. The actions of the IGO indicate that they are either unaware that a hospital treats patients or they don't care or both. They act as though they are functioning in a factory, a storehouse or a military base.

Second, with reference to a denial of a reasonable interpretation of a university-VA affiliation, the mission of the university and VA are comingled. Both institutions have common goals in patient care, teaching, and research. A reasonable affiliation between the University and the VA provides mutual gain to each.

In today's modern VA medical center with a university affiliation, there are now many sections in which state of the art care could not occur without university resources and input. The immediate gain of such university input is to the veteran patient who expects and deserves medical care second to none.

The scenario described in appendix I of my letter to Senator Cranston indicates that the IGO believes that the university must provide a one-way conduit into a sump called the VA hospital. This is certainly not a reasonable concept of a university-VA affiliation. In a marriage, such an expectation results in divorce.

The atmosphere created by IGO in our health-care facility and their attitude toward academic rights and privileges, that is, publishing, is repugnant to our faculty. If such approaches are nurtured, no university faculty member will be willing to remain at this or any other VA hospital in the country.

Our modern day VA hospital affiliated with a university is staffed by eminently qualified faculty, including many senior faculty members. The VA hospital is no longer a training ground for junior faculty as it was in the 1950's and 1960's. Such a faculty has the mobility to leave this VA hospital but the VA patients do not have such a choice. VA patients expect and deserve better care than they would receive in the absence of a university presence.

With respect to recommendations for improving investigatory methods at VA hospitals, the question is whether the IGO can provide appropriate auditors at health care facilities. An investigator cannot be assigned to a naval base one day and a VA hospital the next. The experience in San Diego and other VA hospitals affiliated with a university indicates that the IGO has not provided auditors with an acceptable loss/gain ratio. Their comportment indicates that their experience has been gained by dealing with non-health-care professionals in environments other than hospitals and that they are insensitive to the reality of VA-university affiliations.

The following are nine specific recommendations for improving investigations at VA hospitals.

One, auditors of health-care facilities should be specially trained in the functions of a hospital and in dealing with health-care professionals.

Two, auditors cannot function autonomously. They should enter a health-care facility under the continuing guidance of the hospital director. It is the hospital director who is charged with responsibility for operating the hospital.

Three, auditors should enter a VA hospital affiliated with a university with the prior knowledge of the dean's committee. In sensitive matters, such foreknowledge can be restricted to a subcommittee of the dean's committee specifically to include the hospital director and the dean. If this process is not followed, the process of auditing itself denies the affiliation. If this process is not followed, the auditing mechanism provides a ready means of chastising one part of the affiliation, the university.

Four, auditors should not enter active patient care units without approval of the chief of service.

Five, auditors must follow due process and cannot violate civil rights.

Six, a person being audited must be immediately notified of the specific area being audited. Auditors must have predefined limits and cannot extend autonomously their investigations.

Seven, final reports should be made available to the person audited, the hospital director and the Dean's Committee.

Eight, seminars should be held throughout the VA hospital system to inform employees of their rights in whatever auditing system is implemented. Such seminars should be followed by a written summary of rights. Seminars should be conducted by components of the Government which are independent of the auditing system.

Ninth and finally, the University-VA affiliation should be interpreted reasonably. Auditors should be sensitive to the reality of such affiliations and the mutual benefits that accrue to both the VA and the university as a result of such affiliations.

Thank you very much and I will be delighted to try to answer any questions.

Mr. STEINBERG. Thank you, Dr. Tisi, and thank you for making constructive suggestions as well as indicating your concerns about recent experiences with the Inspector General's Office.

[The prepared statement of Dr. Gennaro M. Tisi and other related materials follow:]

UNIVERSITY OF CALIFORNIA, SAN DIEGO

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VICE CHANCELLOR FOR HEALTH SCIENCES
DEAN, SCHOOL OF MEDICINE

LA JOLLA, CALIFORNIA 92093

PREPARED STATEMENT OF DR. GENNARO M. TISI, ASSOCIATE PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN DIEGO, SCHOOL OF MEDICINE, CHIEF, PULMONARY SECTION, SAN DIEGO VETERANS' ADMINISTRATION HOSPITAL

Thank you for the opportunity to describe the actions and comportment of the Inspector General's Office (IGO) at the San Diego Veterans Medical Center during the eight day period from May 1-8, 1980. During this time, a single representative of the IGO succeeded in: (1) interferring and interrupting patient care; (2) violating my civil rights and those of my staff; and, (3) denying a reasonable interpretation of a University-VA affiliation agreement. A summary of each of these three points is enclosed in APPENDIX I to this letter.

By way of introduction, I am an Associate Professor of Medicine at the University of California San Diego School of Medicine (my curriculum vitae is attached as APPENDIX II). I have been a member of the faculty at UCSD since 1968, and I have been Chief of the Pulmonary Section at the San Diego Veterans Medical Center since 1972. As Chief of the Pulmonary Section, I am directly responsible for the daily care of approximately 50 hospitalized patients and various types of lung disease. As you know, lung disease is one of the most common diseases afflicting our Veterans.

It is this active, patient section of our Health Care Facility which the IGO entered on May 1, 1980.

In medicine I have been trained to make medical judgements based on what is referred to as a RISK/BENEFIT RATIO. If the risk to my patient from a given intervention, i.e., diagnostic procedure, medication, surgery, etc. is high, and the benefit of the intervention low, then I would not dare to subject my patient to such an intervention.

The activities of the IGO, in my opinion, may be evaluated by a similar approach: i.e., not a risk/benefit ratio, but a LOSS/GAIN RATIO.

With reference to gain, the IGO was established to promote the economy, efficiency, and effectiveness of government programs and to prevent fraud. The Congress will have to evaluate the potential gain provided by IGO.

With reference to loss, I have accepted your invitation to speak before the Committee on Veterans' Affairs, to provide input that there is an unacceptable and intolerable loss which results from the presence of the IGO in our Health Care Facilities -- our VA Hospitals. A summary of the losses in the area of patient care, civil rights, and University-VA affiliation is included in APPENDIX I.

The following is a brief description of the consequences of the losses in each of these three areas:

1. Interference and Interruption of Patient Care --

   The primary mission of our VA Hospital is patient care. As such, our Hospital deals in a service and not a product.

   Fortunately, no VA patient was irreversably affected by the interference and interruption by the IGO of the patient care activities of the Pulmonary Section. They were inconvenienced to be sure, and their evaluations were delayed . . ., but none died. THE POINT IS THAT SUCH A CATASTROPHY COULD HAVE OCCURRED AND IS A LIKELY PROBABILITY WHEN NON-HEALTH CARE PROFESSIONALS ARE TURNED LOOSE ON A HEALTH CARE FACILITY AND PLACE THEIR PERCEPTION OF ADMINISTRATION PROCESSES ABOVE PATIENT CARE. The actions of IGO indicate that they are either unaware that a hospital treats patients, or they don't care, or both. They act as though they are functioning in a factory, a storehouse, or a military base.

2. Violation of Civil Rights --

   The procedures followed by IGO in their investigation of my Section can be characterized as goon-like. I do not mean to be disrespectful by the use of the term goon, but do so in accordance with the dictionary definition of the term . . . a thug hired for purposes of intimidation. The one emotion that I and each of the members of my Section experienced at the hands of IGO was intimidation.

   As one by one my civil rights and those of my staff vanished before my eyes, I became terrorized. The IGO functioned in an atmosphere of intimidation and the knowledge that the IGO had inteferred with some sections of this Hospital for months. Faced with such a prospect, I became terrorized for my patients, my staff, and myself.

   An active patient care unit could not function in the atmosphere that was created.

   The techniques followed by IGO indicated that the investigation believed that the ends justify the means. Further, the IGO functioned as though the United States is populated by two classes of citizens . . . federal and non-federal employees. Further, by some unconstitutional mumbo-jumbo, they function as though the civil rights of these two classes are different.

Their motto might be described as "expediency before justice."

3. Denial of a Reasonable University-VA Affiliation --

The mission of the University and VA are comingled. Both institutions have common goals in patient care, teaching, and research. A reasonable affiliation between the University and the VA provides mutual gain to each.

In today's modern VA Medical Center with a university affiliation, there are now many sections in which state of the art care could not occur without university resources and input. The immediate gain of such university input is to the Veteran patient who expects and deserves medical care second to none.

The scenario described in APPENDIX I indicates that the IGO believes that the University must provide a one-way conduit into a sump called the VA Hospital. This is certainly not a reasonable concept of a university-VA affiliation. In a marriage, such an expectation results in divorce.

The atmosphere created by IGO in our Health Care Facility, and their attitude to academic rights and privileges, i.e., publishing, is repugnant to our faculty. If such approaches are nurtured, no University faculty member will be willing to remain at this or any other VA Hospital in the country.

Our modern day VA Hospital affiliated with a university is staffed by eminantly qualified faculty, including many senior faculty members . . . the VA Hospital is no longer a training ground for junior faculty as it was in the 1950's and 1960's.

SUCH A FACULTY HAS THE MOBILITY TO LEAVE THIS VA HOSPITAL, BUT THE VA PATIENTS DO NOT HAVE SUCH A CHOICE. VA patients expect and deserve better care than they would receive in the absence of a university presence.

In conclusion, the investigation of the IGO into the Pulmonary Section of the San Diego Veterans Medical Center this eight day period was, and is, repugnant and revolting. It can only be perceived for what it was . . . an investigation with incredible potential loss to the VA and the Univeristy . . . loss to patients, citizens, and faculty. Yet, it must also be recognized as an investigation with no conceivable gain. In my opinion, the loss/gain ratio of this investigation is infinite.

The IGO has been referred to by many as a gestapo. The investigator from the IGO laughed when he used the term in the course of one of his interviews. I am here to testify that it is not funny.

Respectfully submitted,

Gennaro M. Tisi

Gennaro M. Tisi, M.D.
Associate Professor of Medicine
UCSD School of Medicine
Chief, Pulmonary Section
San Diego Veterans Administration Hospital

Attachments (3 appendices)

APPENDIX I

On the late morning of Thursday, May 1, 1980, an investigator from the IGO entered my office, flashed his badge, gave me his name and then proceeded to interrogate me. He did so on the basis of an anonymous letter which made two allegations couched in terms like "may" or "might". I DENIED THE CHARGES AND SAID THAT THEY WERE LIBELOUS. This made no difference. In the absence of one shred of data, this man entered my professional, academic, and personal life. His investigation placed me in the position that I had to prove the allegations false. I recall being taught in grammar school that our Constitution was based on the English not the French due process.

WITHIN SEVERAL HOURS, AND CERTAINLY TWENTY-FOUR HOURS, HIS INVESTIGATION PROVED THE ALLEGATIONS TO BE FALSE. Did the investigator leave? Of course not. He intended and did go ahead and interview my secretaries and technicians. I asked him the purpose of such a process and received no answer. I told him that such a process would affect my reputation, but that was of no concern to him.

Consistent with the omnipotent atmosphere in which the IGO functions at our VA Hospital, I asked for help, but no one called off the witch hunt. The investigator had his foot in the door, and as all good witch hunters, he would not go away until he had found something.

I asked for help and was counseled that I should cooperate in the spirit of bringing the investigation to a speedy end. This is good counsel, if you are dealing with reasonable men. Accordingly, I accepted the counsel, and cooperated. The investigator remained.

During this seven-day period, a single investigator succeeded in:

I. INTERFERENCE WITH AND INTERRUPTION OF PATIENT CARE, i.e.,

1. Key personnel were interviewed at his pleasure, outside the Section, and detained for as long as he decided appropriate
2. He chose to gain access to a computer located in the Pulmonary Functions Laboratory during the Hospital workday, when prudent judgement would have dictated that he should have done this at night
3. He deactivated our computor by his unannounced "sneak attack" and thereby made it unavailable for essentially a full day; never once did he ask if it was necessary for patient care or whether it was tied to life support systems as it might well have been with respect to an Intensive or Coronary Care Unit; but then, what does a non-health professional from the IGO know about Intensive Care Units?

4. His investigative, goon-like tactics were such that an active patient care unit like the Pulmonary Section could not function normally

5. His line of questioning about time commitment was such that he couldn't understand why any of our faculty would work in the VA Hospital on a WOC (without compensation) status; he couldn't understand that a faculty member would work evenings and weekends when he wasn't on the time clock; when the whistle blows at 4:30 p.m., the IGO may go home, but patients remain in hospital beds; patients and illness follow a 24-hour time clock in a hospital, and fortunately, our faculty remain to respond to their needs.

Fortunately, no VA patient was adversely affected by this interference and interruption by the IGO of the patient care activities of the Pulmonary Section. THE POINT IS THAT SUCH A CATASTROPHY COULD HAVE OCCURRED AND IS A LIKELY PROBABILITY WHEN NON-HEALTH CARE PROFESSIONALS ARE TURNED LOOSE ON A HEALTH CARE FACILITY AND PLACE THEIR PERCEPTION OF ADMINISTRATIVE PROCESSES ABOVE PATIENT CARE. These actions indicate that they are either unaware that a hospital treats patients, or they don't care, or both. They act as though they are functioning in a factory, a storehouse, or a military base.

II. VIOLATION OF CIVIL RIGHTS, i.e.,

As one by one my civil rights and those of my staff vanished before my eyes, as the investigator entered any part of my life that he choose, and as he functioned autonoumously and unchecked by any component of our professional staff, I became terrorized. He functioned in an atmosphere of intimidation, and, the knowledge that the IGO had interfered with some sections of this Hospital for months. Faced with such a prospect, I became terrorized for my patients, my staff and myself. An active patient care unit could not function in the atmosphere that was created.

The final atmosphere was such that I and my staff no longer believed that we were U.S. citizens, but rather felt that we were being manhandled by the gestapo in Nazi Germany. The following is only a partial list of the civil rights which he violated:

1. He charged that his questions and charges must be answered since we were Federal employees

2. He never read me or most of my staff our rights

3. He rifled through the files in my office giving the impression that I had no right to refuse; drawers were opened which contain records of patients protected as priviledged information; one drawer contains my own health records, and academic records of my promotion within the University of California

4. His interrogation consistently slipped from cajoling to entrapment

5. At the conclusion of each interrogation, he charged each person not to speak to anyone; did this include legal counsel?; if his investigation interrupted and interfered with patient care, as it did, did this include the Chief of Medicine, the Chief of Staff, and the Hospital Director?

6. He told one technician (Mr. Thomas DeGraff) that as a Federal employee he had to respond to his questions about how much income he had reported on his IRS form; he so intimidated this employee that he obtained his personal financial history and private corporate documents (see APPENDIX III)

7. He terrorized one of my secretaries (Ms. Jan Ailshie), led her on by entrapment and his incorrect definition of University-VA functions, and threatened her with imprisonment if she didn't answer all his questions and tell her what he wanted to know

8. At the end of my interviews, he asked that I hand write a complete statement of the content of our interview; he said he would review it and edit it, he would tell me about any additional points he believed should be included, he would have the document typed, and I would sign it as my deposition

9. He asked that in the summary described above, I include my personal philosophy -- I thought to myself, my personal philosophy about what . . . medicine, religion, politics?

10. I was not told of the charges against me until approximately 30 minutes into the interrogation; since the charges were based on a letter, I requested the letter, but have never been given access to it; as a result, I still do not know the exact specifications of the original charges

11. At the very beginning of his interrogation, I asked if I would receive a copy of his final report; he said that I would not and that I had no right to the report; and so ends the ultimate in Star-Chamber proceedings.

This completes the scenario to Tuesday, afternoon, May 6, 1980. On that afternoon, the investigator from IGO extended his investigation into the activity of my University granted and funded sabbatical year. . . the writing of a medical textbook. By this action, he demonstrated that he and his immediate supervisor or supervisors function without a reasonable concept of a University-VA affiliation, and without sensitivity of the academic functions and prerogatives of a faculty. The following is a summary of the actions of IGO in this area.

III UNIVERSITY-VA AFFILIATION, i.e.,

During the course of an interview with one secretary, she made a vindictive comment that a second secretary (Ms. Jan Ailshie) had typed a part, or parts, or my book. The investigator, through previous interviews, knew of the inter-personal problems between these two secretaries, and accordingly he knew that the comment was vindictive.

Nevertheless, he combined this vindictive comment with a lack of care or appreciation or both, of the reality of a University-VA affiliation and INTRUDED INTO MY SABBATICAL YEAR. My sabbatical was granted and fully funded by the University of California San Diego School of Medicine for the expressed purpose of writing a medical textbook (Pulmonary Physiology in Clinical Medicine published by Williams and Wilkins, Baltimore, Maryland in March 1980). The investigator from IGO chose to extend his investigation to my sabbatical and book despite the fact that these two aspects were not included inthe original anonymous letter.

During the investigator's "interview" with Ms. Jan Ailshie, he intimidated her and threatened her with inprisonment unless she told him what he wanted to know, and what she had done, i.e., the typing of my book. She returned to the Pulmonary Section trembling and out of control. Her appearance was witnessed by Dr. Marvin Dunn, Acting Dean of the UCSD School of Medicine, Dr. William Hollingsworth, Chief of Medicine at the VA, and by myself.

The final manuscript of my book was 555 pages. Williams and Wilkins (my publishers) paid three secretaries enough money to allow for 1,100 pages of typing (sufficient to type my manuscript twice). Further, the manuscript was typed on bond paper purchased at the UCSD Bookstore and with privately purchased IBM typewriter ribbons. The art work, graphics, and photographic prints were performed in the Office of Learning Resources at the UCSD School of Medicine -- these costs were paid by Williams and Wilkins. The final manuscript was xeroxed (6 copies) by a private firm in San Diego.

DESPITE THESE DATA, IGO CHOSE TO FOCUS ON WHETHER ANY VA TYPING TIME HAD BEEN USED FOR A "UNIVERSITY FUNCTION" AND A "COMMERCIAL VENTURE", i.e., the words used to refer to my book.

With reference to the term "UNIVERSITY FUNCTION", the investigator from IGO said that he didn't care if a University employee spent full time doing "VA functions," but a VA employee could spend no time doing a "University function." SO MUCH FOR A REASONABLE INTERPRETATION OF A UNIVERSITY-VA AFFILIATION. I am sure that this particular

investigator couldn't define the terms, "University function" and "VA function." I am also sure that in his mind he had succeeded in separating the comingled missions of the University and the VA in the areas of patient care, teaching, and research.

1. VA SECRETARIAL RESOURCES WERE NOT MISUSED. There are two secretaries with desks next to each other: one secretary is fully funded by the VA, the other fully funded by the University. These two secretaries are a representation of the University-VA affiliation in microcosm. Their functions are comingled. During a given 80-hour workweek for the two secretaries, 60 hours or more are spent on direct VA patient related activities, and 20 hours or less on academic pursuits, i.e., grants, abstracts, manuscripts, lecture materials, etc.

2. IF ANYTHING, THE UNIVERSITY SECRETARIAL RESOURCE WAS ABUSED. The University secretary is salaried by "soft" funds available from the Pulmonary Division at UCSD. This secretarial position was not discontinued or withdrawn during my sabbatical. It continued to be used primarily (more than 75%) for VA patient related activities. Without this position, these patient related activities could not have been fulfilled.

3. HAD THE UNIVERSITY FUNDED SECRETARY BEEN DIVERTED FROM THE VA PATIENT ACTIVITIES (WHICH SHE WAS NOT), SHE WOULD HAVE HAD SUFFICIENT TYPING TIME TO TYPE MY MANUSCRIPT, NOT TWICE BUT FOURTEEN TIMES: i.e., during my sabbatical, this secretary had 1,440 hours of available typing time; working from a clean copy, she could type 5 double-spaced pages per hour for a total of 7,200 pages; the final manuscript of my book was 555 double spaced pages; accordingly, she had sufficient time to type my book 14 times.

The use of the term, "commercial venture" by IGO to refer to my book indicates that IGO is insensitive to and conceptually opposed to academic pursuits. If such a philosophy is not checked, it would totally destroy the possibility of a University-VA affiliation.

1. My textbook is the culmination of 25 years of medical training, and 18 years of clinical experience, teaching and research.

2. My textbook was written to advance medical knowledge and patient care (as indicated in the preface to my book).

3. It is the product of a University funded sabbatical.

4. The very title of my book, Pulmonary Physiology in Clinical Medicine, indicates its "non-commercial" nature.

In conclusion, the investigation of IGD into my sabbatical year and my textbook was, and is, repugnant and revolting. It can only be perceived for what it was . . . an investigation with incredible potential loss to the University and the VA, and yet, it must also be recognized as an investigation with no conceivable gain.

APPENDIX II
To 6/2/80 letter to Senator Cranston
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CURRICULUM VITAE

TISI, Gennaro Michael:

Date of Birth:	September 26, 1935	
Place of Birth:	New York, New York	
Social Security No:	118-28-6161	
Married:	Margaret Anne (Coniglare)	September 8, 1937
Children:	Judith	March 1, 1961
	Steven	November 26, 1962
	Karen	April 14, 1966

EDUCATION:

St. Francis Xavier High School, New York, New York	1952
Fordham University, New York, New York	1956
Majors: Chemistry, Biology, Philosophy, B.S.	
Georgetown University Medical School, Washington, D.C., M.D.	1960

POST-GRADUATE TRAINING:

Internship, Georgetown University Hospital, Washington, D.C.	1960-61
Medical Officer, United States Navy, Active Duty	1961-63
Assistant Resident, Internal Medicine, Georgetown University Hospital, Washington, D.C.	1963-64
Resident, Internal Medicine, Georgetown University Hospital, Washington, D.C.	1964-65
Post-doctoral, National Heart Institute, Fellowship: Pulmonary Division, Georgetown University Hospital, Washington, D.C.	1965-67
Research Trainee, Cardiovascular Research Institute, San Francisco Medical Center, University of California, San Francisco, Ca.	1967-68

MEMBERSHIP:

Fellow, American College of Physicians
Fellow, American College of Chest Physicians
Western Society for Clinical Research
American Federation for Clinical Research
American Thoracic Society
American Physiological Society
California Thoracic Society
Scientific Council, California Thoracic Society

HONORS:

AOA - Georgetown Medical School	
Outstanding Teaching Award, University Hospital Medical Housestaff	1972-73
Outstanding Teaching Award, University of California, San Diego Medical Housestaff	1973-74
UCSD Medical School Kaiser Award Outstanding Medical School Teacher	1977

EDITORIAL BOARDS:

Guest Reviewer - American Review of Respiratory Diseases	1974-present
- Journal of Clinical Investigation	

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Curriculum Vitae - TISI, Gennaro Michael (continued)

ACADEMIC POSITIONS:

Assistant Professor of Medicine, University of California San Diego, School of Medicine	1968-73
Consultant in Pulmonary Disease, U.S. Naval Hospital, San Diego, Ca.	1968-present
Consultant in Pulmonary Disease, U.S. Naval Hospital, Camp Pendleton, Ca.	1971-present
Director, Pulmonary Physiology Laboratory, University Hobpital, San Diego, Ca.	1968-72
Chief, Pulmonary Section, Department of Medicine, Veterans Administration Hospital, San Diego, Ca.	1972-present
Associate Professor of Medicine, University of California, San Diego, School of Medicine	1973-present
Acting Chief of Medicine, Department of Medicine, Veterans Administration Hospital, San Diego, Ca.	July-Nov 1974

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APPENDIX 3

June 3, 1980

The Honorable Alan Cranston
United States Senate
Subcommittee on Veterans Affairs
Washington, D.C.

Dear Mr. Cranston,

I am a supervisory medical technician at the Veterans Administration Hospital in San Diego. I have been employed in that capacity for eight years, since the opening of the hospital. My duties include administrative support and operation and programming of a Data General Eclipse computer used in the Pulmonary Section of the SDVAH.

On Thursday, May 1, 1980 I was asked to go to the Management Analyst's office for a few minutes. When I got there I was introduced to two investigators from the Inspector Generals Office. They asked several questions about the use of the Eclipse computer in the Pulmonary Section. Following that, they asked me to show them the computer and introduce them to the Chief of the Pulmonary Section, Dr. Gennaro Tisi. The following events ensued:

1) I was asked to stop the normal diagnostic patient tests from being run on the computer and to "dump" the contents of all disk files and magnetic tapes in the computer room.

2) After complying with those requests, I was joined by Dr. Tisi and one of the investigators. Dr. Tisi asked if I had been informed of the nature of the visit of the investigators and one of the investigators responded "This is my investigation and I'd like to handle it in my own way".

3) The computer room was searched, desks and file cabinets opened, and the connections into and out of the computer were inspected.

4) After Dr. Tisi had left the room, I was asked to accompany the investigators back to the first floor. This occured about two hours after I first met the investigators. They informed me that two allegations had been made against myself and others. I denied both allegations. They then informed me that this was an investigation into those charges and that I must cooperate in the investigation, must answer all questions put to me, and could only request the presence of an attorney or take the Fifth Amendment to avoid answering any question. During the questioning I was asked for the gross amount appearing on my 1979 Federal Income Tax return. Since the amount I responded with was substantially above that of my Federal employment, they asked for the source of any additional (non-VA) income. Feeling I had no choice but to divulge the information requested, I told them the income came from my work (program consultant) with a private California corporation. Several questions regarding the members and salary distributions of that corporation were asked and answered.

5) The interrogation lasted for three hours. Following the questioning I was told to prepare a handwritten statement covering the responses to the questions asked of me and was told that these statements would be edited and transcribed and submitted to me for signature. I was also warned, under threat of prosection, not to disclose to anyone the nature of the investigation being conducted. The computer was unavailable for use for over six hours on that day.

6) About ten days later I was asked to see one of the investigators for submission of the written statement. He read the statement and asked if I would like to go into more detail on my affiliation with the corporation to which I belong. I responded "No" since it was obvious after the first day that there was no misuse of the computer. In the following conversation one of the investigators stated that "I don't care if an employee is full time VA funded or one-eighth VA funded, and I don't care about the Sharing Agreement between the University (of California at San Diego) and the VA. If I can find any person spending one minute on non-VA activity, I'll go after him."

7) About four days later I was asked to appear before two other IGO employees, one of them being the Deputy Inspector General. They asked me about the questioning I was subjected to and asked whether any of the technicians had been inconvenienced by the lack of computer availability. I responded "No. the technicians work from 8:00 AM to 4:30 PM. If they can't get access to the computer, they can always run the test results the next day. The people who suffered are the patients who couldn't get their test results and the doctors who were awaiting the test results (some of the patients were scheduled for surgery the next day)". They concluded the meeting by saying "Even though the questions asked of you may have been a little out of line, don't you feel that the answers you provided may have helped to speed up the investigation?"

I feel that investigations of this type should be conducted by people that have a sensitivity for the employees responsibility to the conduct of patient management. The computer should not have been made unavailable for patient diagnosis without first consulting with the Chief of the Pulmonary Section, and then with the Chief of the Medical Service. Secondly, the investigation was carried out in an aura of fear and intimidation. Questions which the investigator knew to be outside the scope of the allegations were asked with the hope that the intimidating aspect of the questioning would provide them with answers they could not normally get.

Yours very tr..ly

Thomas E. DeGraff

Thomas E. DeGraff

68-178 O—80——12

Medical Center

3350 La Jolla Village Drive
San Diego, CA 92161

Veterans Administration

June 9, 1980

Senator Alan Cranston
Chair, Committee on Veterans' Affairs
Russell Senate Office Building, Room 410
Washington, D.C. 20510

Honorable Alan Cranston,

My name is Janis Ailshie, the clerk-stenographer of the Pulmonary Department at the San Diego Veterans Administration Medical Center. This is my personal statement I am submitting for the records.

On May 6, 1980 I was called by a representative from the Inspector General's Office to meet with him, which I did at 3:30 p.m. Our meeting started out with the representative introducing himself as an investigator from the Inspector General's Office. He said that he was not going to officially swear me in, but that he was going to be asking me several questions that I would be required to answer. Well he asked several questions about pulmonary personnel work performance, and I answered all of his questions. The representative asked if I ever typed medical manuscripts at work and I answered that I have typed many medical manuscripts, abstracts, and grants during my past 2 years 8 months employment in the Pulmonary Department. He asked if I have typed any large projects and I said yes. He asked me if I was coerced into doing any job that I felt for any reason was not right to do and I told him no. He asked me if I ever felt obligated to do work in order not to cause friction in the department and I told him no.

The representative said that if I do not feel comfortable talking to him that I would have to go through "VA counselors", but that this is a simple matter and that there is no reason to go through counselors that would cause just a prolonged period of time in handling these meetings that could be over in just a short period of time.

The representative hinted around about a particularly large project and asked if I knew what he was talking about. It was decided upon the project he was referring to was a book entitled "Pulmonary Physiology in Clinical Medicine". He asked if this project ever interferred with my VA responsibilities and I told him no. The questions he was asking aroused suspicion as to why he would be asking these. I felt very uncomfortable and uneasy. The questioning was directed at me with accusations that filing of pulmonary patient charts had gotten backlogged and that the typing had came before patient care. My reply to the representative was that working at the "front desk" always involves handling patient workload. Patients either need direction, guidance, or

In Reply, Refer To:

paperwork that needs to be completed and I as the employee at the "front desk" have always handled these matters efficiently and with deep concern for the patient's welfare.

At this point I felt, more than likely, that these accusations had stemmed from the person whom he had a meeting with just before he called me in. This person was a secretary in the pulmonary department, and due to personal conflicts that these accusations had stemmed from a vindictive nature. I told the representative my feelings about this and told him that I wished to no longer continue our meeting. The representative's reply was that if I chose not to continue to answer his questions that I could be putting myself into jeopardy, and that I could be hurting myself if I chose not to answer his questions. So being put that way, I continued the meeting even though I felt his questioning was ill-based.

Over and over again the representative asked if it interferred with my VA workload and I told him no. We discussed the average hours a day I spent typing on the book which varied greatly. There was times I typed on my own time during my lunch break or after work.

Upon completion of this meeting with the representative I was very upset. I was worried over the reasoning for his questioning.

Sincerely,

Janis C. Ailshie

Janis C. Ailshie
Clerk-Stenographer
Pulmonary Department

Dr. BAILEY. Mr. Steinberg, may I interrupt you? I have a plane to catch at 1:30 and I was wondering if you have any questions——

Mr. STEINBERG. Yes, we have a few and I will try to do this right at the outset.

Dr. BAILEY. And I might be excused afterward?

Mr. STEINBERG. Certainly.

In your testimony, as well as Dr. Joseph Rubin's testimony on April 23 at the hearing Senator Stone chaired at the request of the Chair on the VA pacemaker policy, there were various references to your dissatisfaction with the way Inspector General personnel comported themselves at your facility and at the VA hospital.

For the record, could you provide specific instances of activities that you found to be objectionable or of questionable propriety?

Dr. BAILEY. No, I can't; I can through Dr. Rubin. This was testimony provided by him——

Mr. STEINBERG. He did not give us the specifics and if you would discuss this with him and provide it for this hearing record, we would very much appreciate that.

Dr. BAILEY. All right.

[Subsequently, Dr. Joseph P. Bailey submitted the following information:]

MCG

Medical College of Geor
Augusta, Georgia 309

School of Medici
Section of Thoracic and Cardiac Surge
(404) 828-3227 or after 5 p.m. 828-38

June 13, 1980

received
JUN 16 1980

TO: Joseph P. Bailey, M.D.
Associate Dean for Clinical Sciences

FROM: Joseph W. Rubin, M.D.
Associate Professor, Section of Thoracic & Cardiac Surgery

SUBJECT: Inspector General's Investigation of My Conduct at VAMC

(1) Inspectors were present three or more days inquiring into my affairs with MCG before I was made aware of the investigation. They interrogated officials of MRFG and my immediate associates.

(2) When I was summoned I was urged to present myself at the VA, despite having an unstable postoperative patient in ETMH. The inspectors were polite, firm and direct at all times and stated their intention to establish or nullify charges against me concerning "abuse and fraud", etc.

(3) I was advised of my constitutional rights and given the opportunity to retain counsel on my own. (I did not retain an attorney since I perceived no substance in the allegations against me.)

(4) The inspectors proceeded to interrogate me about elements of a personal and private conversation with Mr. John Allen of Pacemaker Diagnostic Clinic of Gainesville, Fla. that took place in my office on August 25, 1978. This conversation appears to have been reported to the Inspector General by Mr. Allen. The Inspectors also quizzed me about my correspondence on MCG stationery with an official at VAC, Dublin, expressing our willingness to have MRFG enter into contract for pacemaker surveillance with that facility. During this interrogation, I was informed that this matter was VA business conducted between VA officials (myself and the corresponding physician at VAC Dublin.) When I informed the Inspectors of my part-time status at VAMC and my freedom as MCG faculty to practice outside the VA system as necessary, I was told that my "affiliation with MCG" had no direct bearing on the manner in which my affairs were to be conducted as long as VA patients were involved!

(5) Following this interchange, I understood that the Inspectors were unfamiliar with VA staffing and, in fact, regarded me as a VA employee affiliated in some way with MCG. I did state that my part-time VA appointment was an assignment of responsibility by MCG and that the VA regulations governing part-time physicians permit medical activities outside VA, including the receipt of fees for service from federal agencies.

Medical College of Georgia

(6) At the conclusion of the first interview, I was sworn to secrecy though I was not informed beforehand of the investigation's covert nature. After the second interview, at which time I was required to attest to my statements, I expressed reluctance to cooperate any further. Some inuendo about adverse outcome was proffered if I refused to participate further. At that time I discovered that the inspectors knew more about me personally than I ever suspected.

JWR/lkt

Mr. STEINBERG. Is it your opinion that the investigation carried out by the Inspector General at the Augusta VA Medical Center had an adverse effect on the operation of the medical school?

Dr. BAILEY. In the context of its overall relationship with the VA, yes.

Mr. STEINBERG. Did it have an adverse effect on any teaching activities, that is the activities vis-a-vis your students?

Dr. BAILEY. Yes; in instances of the pacemaker business you alluded to concerning Dr. Rubin, subsequent to this investigation, the activities of using the medical college pacemaker clinic were discontinued and thereby you demonstrated to the students a lack of adequate followup as far as these patients that previously had pacemakers implanted are concerned.

Mr. STEINBERG. In the event of a future Inspector General investigation at the Augusta VA Medical Center, are there any particular steps you think should be taken by the Inspector General's Office to assure that the investigation does not interfere with patient care or create undue friction among the staff of the medical school, the medical center and the Inspector General's Office?

Dr. BAILEY. Yes, I do. I certainly share many of the points Dr. Tisi has provided you and I feel very strongly that the development of such investigation should hinge around a common understanding through the dean's committee and this involves both institutions in essence.

Mr. STEINBERG. I might note in that regard that the Inspector General stated that they would have a policy henceforth so that the dean would be notified in all instances where there was involvement of medical school personnel.

Dr. BAILEY. I did hear that and I was most heartened by the Inspector General's comments about the evolution of a program that responded to the medical director, obviously one of the major things in my testimony that I felt was important. I think the extremely valuable relationship between the VA and medical school settings has proven itself over and over again throughout this Nation.

I don't feel, and I want to stress that in any way the testimony I have given should be construed to decry the necessity for looking at what we do. I think that's extremely important and have no question about that. But I do think the issue of a separate medically oriented activity as far as this inspection process is concerned, such as has been discussed, but hopefully with this answering to the medical director, is an extremely valuable asset.

Mr. STEINBERG. Would you have any suggestions now or that you might like to provide in writing later for altering the VA timekeeping procedures for part-time physicians?

Dr. BAILEY. I think so. I don't have any specific ones I would give you at this moment but I would certainly provide those to you as part of our report.

Mr. STEINBERG. We would like to have that for the record.

[Subsequently, Dr. Joseph P. Bailey submitted the following information:]

In response to your request for information concerning timekeeping for part-time physicians, I would like to suggest that the Department of Medicine and Surgery formulates its own definition of part-time physicians recognizing that such an appointment is on an annual, not an hourly, basis. This would necessitate the establishment of appropriate timekeeping guidelines. These guidelines should provide for 26 equal salary payments over the course of a year for both full- and part-time physicians. As medical care cannot truly be measured in terms of hours given, the veracity of each part-time physician and physician supervisor is tested each time they are asked to sign a time card. The norm should be the adequacy of service coverage as judged by physicians in supervisory roles. The quantity authorized, that is, the extent of part-time employment, should be determined on the basis of reasonable and customary requirements for the workload and mission of an individual clinical component within a VA Medical Center. It becomes readily apparent whenever a VA physician, full- or part-time, is not meeting the required caseload quantitatively or qualitatively. If a physician's performance is unacceptable, immediate corrective action must be taken by his/her supervisor who is ultimately responsible for the physician's performance. As a consequence, I believe that VA part-time physicians should be treated as full-time physicians appointed under title 38, not as title 5 civil servants.

Mr. STEINBERG. Dr. Cooper and Dr. Tisi, the same request is extended to you for any kinds of suggestions which you might wish to provide us with respect to the timekeeping procedures.

Dr. Bailey, that concludes our questions for you and we hope you will make your airplane and again we thank you very much.

Dr. BAILEY. Thank you very much for allowing me to give testimony.

Mr. STEINBERG. I know that Senator Talmadge who is a mainstay of this committee would wish to welcome you and he certainly will be following your testimony in this matter very closely.

Dr. BAILEY. Thank you very much.

Mr. STEINBERG. Dr. Cooper, in your opinion, what effect has the Inspector General's investigations and other activities of the Inspector General had on the relationships between the VA and affiliated medical schools?

Dr. COOPER. I think, Mr. Steinberg, for many of the reasons pointed out here, that this activity has produced friction between the VA installation and its medical school affiliate and that it has raised questions in the minds of many of the professional staff about the future of the VA medical care system and whether it will permit them to carry out their professional functions in a way that I think they really believe they should carry them out.

The situation could be improved substantially by having the concerns related to quality of care and professional competence of physicians carried out by individuals who understand more about medicine. The overall supervision or evaluation of processes being used by these individuals could certainly be within the realm of the Inspector General.

Mr. STEINBERG. You indicated the issue most frequently drawn to the AAMC's attention with regard to IG investigations is the style of behavior demonstrated by the investigators. Are you aware of

how many medical schools have contacted your office to make complaints regarding the conduct of IG investigations?

Dr. COOPER. We can provide that. I think offhand I can think of at least four.

Mr. STEINBERG. If you would provide that, it would be very helpful, without impinging on whatever confidential sources are involved. I think it would be helpful for all of us to get an idea of the magnitude of the problem and also helpful to the Inspector General to know the locations where people have felt conduct has not been as it should be.

You also talk about review of professional performance of physicians being undertaken only by individuals who possess the training and expertise necessary to evaluate the quality of medical care. Are you aware of instances where IG personnel have attempted to review the professional performance of physicians?

Dr. COOPER. Certainly, as that relates to their evaluation of what they consider quality of care, that does involve professional competence and that I think has been an issue in some of the investigations carried out.

Mr. STEINBERG. With respect to the possibility of a separate office of medical inspector which you have advocated, you spoke at some length about your review of the qualifications listed in the Inspector General's report of his staff and noted that they did not seem to have the qualifications you thought were necessary.

Were the Inspector General to add people with appropriate medical and health-care professional experience and training to his staff, why would that not assure that people with appropriate qualifications, and also objectivity and independence, were reviewing the quality of care and professional competency issues that do arise in certain investigations?

Dr. COOPER. I think in the first place, it would be very difficult for him to recruit an adequate staff in this area. Second, I think it would be difficult within the budget he has and all the responsibilities he has to allocate the resources necessary to produce the broad spectrum of competence and expertise that would be required.

I simply think that being an inspector is not something generally of interest to physicians whose training and experience lead them to desire a different kind of role. I think the only hope of being able to recruit these kinds of people is to have them related to their peers and colleagues in medicine in the Department of Medicine and Surgery.

I might say, Mr. Steinberg, these same criticisms occur in other areas. We've had a great deal of difficulty with FDA inspectors who have gone in to evaluate clinical trials without knowledge of medicine and the way that patient care is conducted. I think it is a general problem and I don't want to identify the Inspector General of the VA as having more problems than anyone else, but it is a serious problem in this whole area of Government investigators where the matter relates to evaluation of medical care and medical competence.

I think, quite wisely, in the Senate report of the Government Operations Committee, they recognized this and did so state.

Mr. STEINBERG. Dr. Cooper, you make reference to the need for persons under investigation to have counsel present. Have you received specific complaints where an individual has requested and been denied the opportu. . to have counsel present?

Dr. COOPER. No, sir, I think it came more in the nature of the fact that the individual was not really aware of the fact that he was able to have counsel present.

Mr. STEINBERG. Is it likely that after this morning, those individuals will be aware of that?

Dr. COOPER. I think recommendations made by the Inspector General are very hopeful in that regard. I do think it cannot be left to simply saying that if the individual request counsel, his request is granted. I think there has to be an educational program that really makes these individuals aware of the fact that they are entitled to counsel.

Mr. STEINBERG. That was discussed, but if the Inspector General should choose not to make that knowledge specifically available to an individual, it could of course be made available to that individual through other means and your organization is one means toward that end possibly?

Dr. COOPER. I think, however, that the VA has a great responsibility in this area because they are the ones carrying out the investigation.

Mr. STEINBERG. Dr. Tisi, we have a few questions of you. You, of course, refer on several occasions in your statement and in your letter to what you believe were violations of your civil rights and those of other VA employees at the San Diego Medical Center and in the course of the Inspector General's conduct of an investigation.

Were you informed at the outset of the investigation that you were the subject of the investigation?

Dr. TISI. Not at the outset, no.

Mr. STEINBERG. I believe it is the policy of the Inspector General as he indicated this morning that that should be done. If in fact it was not done in your case, it would appear as though the proper procedures were not followed, unless of course it is possible that the investigator did not know that at the time he first talked to you, you were, in fact, the subject of the investigation.

Were you informed of the allegations against you?

Dr. TISI. Yes, I would estimate 20 minutes to a half hour into the investigation. I was told that the allegations came from an anonymous letter which made allegations couched in terms of "may" or "might". I asked to see the letter and was told that I could not see the letter and I have not to this day seen the letter.

I was not aware of the specific allegations in the letter. The allegations, which I was told, could have been an interpretation by the individual inspector of what was contained in the letter. When the allegations were finally posed to me, I stated that they were libelous and untrue.

The inspector carried out an investigation over the next 2 hours or so which indicated that the allegations were false. This is the point at which I became intimidated because even though the allegations were proven false, he remained an additional 4 days. Accordingly, I became concerned about the specificity of the allegations and the limits of investigation.

Mr. STEINBERG. When you were advised of his, as you put it, the investigator's interpretation of the substance of the anonymous letter, was that pursuant to your request or did he volunteer what the allegations were?

Dr. TISI. As soon as it was apparent to me that I was the subject of the investigation and that the allegations had come from an anonymous letter, I requested the letter. He said he would show me the letter. He left the room and came back with the letter and said that he had not read that letter in several days, that upon rereading the letter, he could not show it to me and he did not show me the letter.

Mr. STEINBERG. You stated that the Inspector General's interrogation consistently slipped from cajoling to entrapment. Can you explain how you believe the investigator attempted to entrap you?

Dr. TISI. Not entrap me, but one of my secretaries was asked whether she at any time typed abstracts and she admitted she had. The line of questioning then went, have you ever typed grants and have you ever typed manuscripts and have you ever typed lectures and so on with the clear implication that the inspector believed that those functions were university functions and separate from VA functions.

I considered the entire interview of this secretary to be entrapment. Following this interview, this secretary returned to our unit—midafternoon on the 6th—and she was visible trembling. The statement of this secretary has been forwarded to Senator Cranston for the record.

I felt very bad throughout the investigation because of one of the charges the inspector made. He said at the conclusion of each interview that the content of that interview could not be discussed with anyone.

I had two major problems with this. One, when I had made a judgment that patient care was being affected, it was my responsibility to be able to turn to my senior medical officer and tell him that in my opinion medical care was being affected.

Second, when my staff were taken off the unit and brought downstairs, they were unclear as to whether they were the subject of the investigation. I was not in a position to forewarn them and tell them don't worry, they're really looking into allegations that concern me, not you. I did not warn them that they were not the subject of the investigation until the afternoon of the 6th when the secretary came back to our unit and was visibly trembling.

Mr. STEINBERG. Were you given the opportunity to have an attorney present and advised that you could have an attorney present?

Dr. TISI. I was never advised I could have an attorney present. In the beginning I did not believe that one was necessary.

One of the major problems I have had with this entire process was why I became so intimidated by the process that developed. In my self-analysis I came up with the fact that I trusted the system, that I trust people and I cooperated with the investigator.

When I went to my medical superiors and asked them what should I do in this investigation, they said in order to bring it to a speedy resolution, go ahead and further cooperate. It was that combination of trust and cooperation which should have resulted in

the investigation coming to an end within the first or second day. When it did not, I became intimidated.

It was only at this time that ideas of lawyers came up. The lawyer who eventually got involved was university counsel. He got involved only when the investigator freightened the secretary on the 6th of May, and extended his investigation into my sabbatical year and the typing of a manuscript.

Mr. STEINBERG. Did you specifically request at any point that an attorney be present and were you denied the opportunity?

Dr. TISI. I never made such a request during the original investigation and I was not denied such an opportunity. During the investigation of the investigator by the Inspector General's Office on May 13, 1980, university counsel was present.

Mr. STEINBERG. Had you known you could have an attorney present, would you have made that request?

Dr. TISI. Probably not in the beginning—May 1, 1980—no; on Tuesday, the 6th, yes.

Mr. STEINBERG. Did the investigator ask your permission to inspect your files?

Dr. TISI. No, and I was not given the impression this morning—the impression that was given this morning that I had the right to so refuse. The files were open. They do contain VA records, but in addition they contained university files and patient records protected as privileged communication between a patient and his physician. My tenure reviews were in those drawers. I have served on many ad hoc committees for tenure and those records were in the file. It was taken as a matter of course that the inspector had a right to inspect the files, and that I had no right of refusal.

Mr. STEINBERG. I don't think the Inspector General this morning intended to suggest that you could have denied inspection of your file cabinet, for example. He did suggest that they did not consider an individual's desk a matter under their direct purview but—although I believe they suggested that it was their policy to ask permission—in the last analysis, they felt they had to have access to file cabinets in VA space to carry out their investigation. In any event, your permission was not asked?

Dr. TISI. No.

Mr. STEINBERG. You indicated that a computer located in the pulmonary functions laboratory was deactivated as a result of the investigation. Did the investigator seek your permission or the permission of the chief of medicine, chief of staff or the hospital director before any steps were taken to deactivate the computer?

Dr. TISI. I was told—when the investigation was completed—that the director was informed a day or two before the investigation that such an investigation would occur, and that the chief of medicine was similarly informed. They would have to respond as to whether their permission or acquiescence was requested.

Mr. STEINBERG. I'm talking specifically of the deactivation of the computer.

Dr. TISI. They would have to respond to that also. With reference to me, the computer was deactivated without my permission.

I know the investigation was described to my medical superiors as a sneak attack. What the Inspector Generals' Office wanted to do was come in unannounced, which they did, and gain access to

that computer without forewarning, which they did. While one investigator interrogated me in my office, a second investigator deactivated the computer, which was located in another part of the pulmonary unit.

The files of the computer were listed and during that time it was not available for patient management. The library of the computer was also listed. The process during which the computer was deactivated extended over at least 2 to 2½ hours.

This computer has a large enough capability that it could have been connected to an intensive care unit, but it wasn't. Similar computers are hooked into intensive care units. They are hooked into life support systems. Had that been the case in this particular instance, it would have been truly a catastrophe. This area of patient care is described at length in my letter to Senator Cranston. Fortunately, the computer was only being used for data reduction of pulmonary function data.

Mr. STEINBERG. Was it ever used at any time for the purposes you indicated it might be used for?

Dr. TISI. No, it never has been but it will be in the future. Our intensive care unit will be remodeled and this particular computer will be used for that function.

Mr. STEINBERG. So in the actual instance, no harm to a patient was done by deactivation of that computer for that period of time?

Dr. TISI. No; in the generic sense. However, when you do pulmonary functions on patients, one of the questions you are trying to answer for a surgeon is can the patient go to surgery the next day? There were patients who came to our laboratory on May 1, 1980 to be evaluated for surgery the next day. Since the computer was deactivated on Thursday afternoon, the 1st of May, I don't know how those patients could have gone to surgery the next day. Accordingly, there was inconvenience but certainly not harm.

Mr. STEINBERG. Is it possible the Inspector General's investigator might have known that the computer was not being used for direct patient care purposes before a decision was made to deactivate it?

Dr. TISI. He would have to respond to that. In my judgment, the information the investigator gained from that computer could have been so gained outside of the ordinary workday. He had a well-qualified computer expert with him and that gentleman could have gained access to that computer at 5 o'clock at night or at midnight and accomplished the same functions he accomplished during the workday.

Mr. STEINBERG. That concludes our questions for you and Dr. Cooper and we appreciate very much your being here. We will be pursuing this matter and may have some written questions to submit to you. Again, we thank you both.

Now we will have a panel of officials from the Veterans' Administration, if they would come forward: Rufus H. Wilson, Deputy Administrator, Veterans' Administration; Dr. Donald L. Custis, Chief Medical Director, Veterans' Administration; and Mr. John Hagen, Deputy Chief Benefits Director, Veterans' Administration.

We asked you here, as you know, because of the concern of the committee about the relationship between the Inspector General's Office and the individual major components of the agency, namely in these instances the Office of the Administrator, Department of

Medicine and Surgery and Department of Veterans' Benefits. There has been considerable discussion this morning about those relationships.

Initially, Rufus, we would be delighted to have any observations you might wish to share with us about the matters discussed. We do have specific questions we would like to pose to you but we would welcome any general observations you would like to make.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF THE VETERANS' ADMINISTRATION: RUFUS H. WILSON, DEPUTY ADMINISTRATOR, VETERANS' ADMINISTRATION; DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR; JOHN W. HAGAN, DEPUTY CHIEF BENEFITS DIRECTOR, ACCOMPANIED BY ROBERT E. COY, DEPUTY GENERAL COUNSEL

Mr. WILSON. If I may, Mr. Steinberg, I would like to submit for the record a short statement?

Mr. STEINBERG. We would be pleased to receive it.

Mr. WILSON. As you know, we established the Office of Inspector General at the Veterans' Administration prior to the time the Congress acted on legislation to establish it more officially by law. We had it in existence about 1 year prior to that time.

Mr. Allan Reynolds was appointed by the Administrator to be our Inspector General. Later on he was reappointed by the President and then confirmed by the Senate. We have had an excellent relationship with him since the day he came on board. He went through the painful process of building up a staff considerably in excess of what had previously been in both the audit and investigative functions of the Veterans' Administration.

A General Accounting Office report stated that the VA had the least audit capability of any major agency in the Government and I think we probably still have but it is considerably more than it used to be.

We have been scrupulous in making sure that the Inspector General maintained his independence. But even as he has maintained that independence, we have had a most cooperative relationship with him.

I am on the phone with him usually one or two times a day and we see each other quite often. The same is true of the Administrator. He and his staff have been given some difficult assignments and they have performed well.

With respect to some of the comments made this morning as to the possibility of the appointment of a medical inspector, we have carefully considered that matter over a period of time. I recall that Mr. Reynolds discussed it with me shortly after he came on board. He also discussed it with the Administrator and the then Chief Medical Director.

He knew and we knew of the fine line that exists between the assessment of good medical care and the assessment of other matters. We knew that there has to be a good line of communication with the medical community. We knew that if he had this medical capability of assessment of quality of care within his own office, nevertheless there would still be lines of communication from medical schools and hospitals directly back to the Chief Medical Director. We considered the possibility of having a medical assess-

ment factor in the Inspector General's office and we compared that to the possibility of having a medical inspector reporting directly to the Chief Medical Director. We came to the conclusion that that was the best way to go.

Dr. Custis came to the same conclusion and he and Mr. Reynolds have discussed it with the Administrator and me. Papers have been prepared which would implement this kind of procedure. They have not been finalized as yet; they are currently going through one final review in the Department of Medicine and Surgery and thereafter will be considered by the General Counsel and then by the Administrator and me.

Prior to the time we make the final decision, we will take into consideration all that we heard at the hearing this morning. We will take into consideration the concerns of the General Accounting Office and the concerns of members of the committee.

But it is our belief that this is the direction we ought to take. This will not impinge upon the integrity and independence of the Inspector General. He will still have his basic obligation. We think this will improve our relationships, not only with the medical community but will be something that will be very effective for the Veteran's Administration.

With that, Mr. Steinberg, I would be pleased to respond to your questions.

Mr. STEINBERG. We appreciate those comments and we also appreciate the sensitivity and complexity of the issue that you just described. Can you provide a specific example or set of examples where you feel the Office of Inspector General has been of material benefit in improving the effectiveness of a particular program within the agency?

Mr. WILSON. Yes, sir. I think it has been of particular benefit with respect to the overpayment problem and with respect to the allegations of patient abuse in the hospital system by employees and patients. I think he made a material contribution with respect to the Manhattan hospital investigation.

The risk analysis setup that he has put into effect has been of assistance. More than anything else I think our Inspector General has made us more sensitive to the whole idea of prevention of waste, fraud, abuse, and mismanagement. I think, however, we had a considerable amount of sensitivity prior to the time he came onboard because we previously had an audit function, and an investigative function.

I think there is no question that that has been brought more forcibly to the forefront since the Inspector General concept was placed into effect. I think that's true throughout the country and not only in the Central Office.

Mr. STEINBERG. Are there any areas other than perhaps in the medical area where you believe the Office of the Inspector General lacks the proper expertise to conduct an adequate investigation or audit?

Mr. WILSON. I would suspect he would lack the capability and the technical expertise in certain technical areas of the loan guaranty program and perhaps the very technical areas of the compensation and pension program. But I think generally he does have the expertise that he needs.

Mr. STEINBERG. Is there any contemplation to establish any other investigative units in other departments in the agency outside the Inspector General's Office?

Mr. WILSON. I have had no discussions in that regard. .

Mr. STEINBERG. Given your vast experience within the Veterans' Administration, do you personally have any recommendations to share with the Committee in regard to its performance of its oversight responsibilities on this issue or to share with the Inspector General regarding his carrying out the various duties and responsibilities under the Inspector General Act?

Mr. WILSON. I would like to think about it a little bit, Mr. Steinberg, and provide comments for the record. I think there is no question that we always have to be extremely sensitive as we send investigators and auditors around the country to field stations. I think there is no question that people do sometimes feel put upon.

I think they sometimes feel intimidated somewhat by the mere fact that an investigator is talking to them and I think that's human nature. I think we always have to train our people to be sensitive in that regard.

Mr. STEINBERG. The GAO in its testimony referred to the fact that more than a year elapsed between the time a draft report regarding drug loss and accountability at VA medical centers was submitted to the Department of Medicine and Surgery and the time when you concurred in the final recommendations.

Is there a need to improve the process for expediting the handling of these recommendations and the making of subsequent comments and reports?

Mr. WILSON. Yes, there probably is. However, I would say while a year did elapse, as I recall it, there were numerous discussions that took place, pieces of paper went back and forth. The whole problem of accountability for drugs is not a simple one; it's very complex. We had a briefing for the Administrator yesterday with respect to the entire matter. It is under day-to-day discussion.

The Inspector General had to take a considerable amount of time before he perfected a recommendation in his own mind. To answer your broad question, can and ought there to be improvements, I think there can and always should be improvements. I am constantly on the lookout for them.

Mr. STEINBERG. Is adequate priority attached in your office to reviewing recommendations and annual reports of the Inspector General?

Mr. WILSON. They come into our mailroom from his office and go to my executive assistant for his personal review; he has some background in that field. They then come to me and I give them the highest priority.

Mr. STEINBERG. Is it your principal responsibility—rather than the Administrator's—to handle general relationships with the Inspector General?

Mr. WILSON. I think that would be a fair statement, yes, sir.

Mr. STEINBERG. Both the GAO——

Mr. WILSON. Mr. Steinberg, the Administrator also has a very personal relationship with the Inspector General. There is open and free communication as well there as with my office.

Mr. STEINBERG. Both the GAO in its testimony and the Inspector General in his reports and testimony have indicated that the lack of sufficient staffing is hampering the Inspector General Office's ability to carry out its responsibilities. For example, this understaffing seems to have necessitated a switch to 5-year cyclical audits at medical centers instead of the current 3-year cycle.

What are the prospects for providing additional personnel to the IG when the current freeze on personnel hiring is lifted?

Mr. WILSON. I would think that there will be some attempt to get the Inspector General increased personnel. But I suspect he will not get anywhere near what he will request and I think that's a fact of life in the Government these days and a necessary fact of life. I saw a piece of paper that would indicate that to do everything he would like to do and do it well, he would need about 200 additional people and I just don't think that's in the cards. But I do think it would be much better to have a 3-year cycle than a 5-year cycle.

I think we could effectively use more investigators and more auditors. But I think that given the restraints under which we operate and under which the Congress has to operate, in people, that if he gets an increase, it will be a limited one.

Mr. STEINBERG. In terms of a reasonable and realistic assessment of staffing needs, do you agree with the resource requirements as shown in the appendix to Mr. Reynold's testimony this morning?

Mr. WILSON. I have not fully analyzed what he perceives to be his resource needs. But if the figure I gave of 200 is correct, I agree he could use that number of additional employees. But I do not believe, given the total restraints we have in the Veteran's Administration and our total needs, I could recommend to the Administrator that he ask Congress for that number of people or anywhere close to it.

Mr. STEINBERG. Dr. Custis, would you like to comment generally on the relationship that exists today and has existed since the establishment of the Inspector General between the Department of Medicine and Surgery and the Inspector General's Office?

Dr. CUSTIS. Yes, Mr. Chairman. I would like, however, to start out by saying that I find GAO's recommendation as to methodology of surveillance for professional performance and quality of care to be unacceptable. I agree with everything the Inspector General had to say on this issue this morning.

I find the Inspector General a most reasonable, sensitive, sincere and competent individual and I feel sure that if we are permitted to do so we could work out among ourselves an arrangement that will best serve the purpose of our hospitals, our affiliate schools and our patients.

Mr. Reynolds and I are guided in our negotiations, for setting up spheres of interest and methodology for review of professional performance and quality of care, by our General Counsel who, from early in the game, has provided his interpretation of the Inspector General legislation, in 1978.

It was his opinion that the Inspector General in this area had a limited mandate and did not have the qualifications to carry out this particular phase of review. Parenthetically, the same opinion

came to us from the staff of Senator Ribicoff's committee, the Government Operations Committee who authored the legislation.

I personally was told informally by their counsel that if Congress ever intended to put into law a system that would stand as an evaluator of quality of patient care, they had yet to write that law. I think Congress in its wisdom during the passage of Public Law 92-641, in their concern about fraud and abuse in medicare, by instituting the PSRO's, gave deference to the concept of peer review.

I believe, Mr. Steinberg, that if the public ever denies the validity of peer review, it will be a sad day for medicine for the legal profession and for society itself. It will certainly, if this is done, have no precedent. There is ample precedent for just the opposite.

In the case of military medicine, I know from personal experience how that system works and it has been working for a good many years. There is an Inspector General of the service and there is also an Inspector General for Medicine. The two work very well together.

Where there are gray areas, they join forces. But there is a clear delineation for responsibility for quality of care and professional performance, a clear delineation which is given to the surgeon general.

Mr. STEINBERG. To whom does the Inspector General for Medicine report?

Dr. CUSTIS. The surgeon general. He also wears a second hat and responds to requests for help from the service inspector general. But their working relationship, in my experience, was never less than very satisfactory.

Finally, I would say that under title 38, the Chief Medical Director of the Veterans' Administration has clearly spelled out for him responsibility for surveillance of professional performance and quality of medical care. He also has responsibility for investigations of such untoward incidents as was put this morning at the VA hospital in Washington.

There would be a medical investigative board set up to look at that situation. If any infractions are found as regards professional performance, it is the Chief Medical Director who is the ultimate authority as regards discipline in that case.

It is the Chief Medical Director who is charged with setting up the system for this review. I would welcome the Inspector General seeing to it that those systems are in place, that I do my job, but not that he do my job for me.

Mr. STEINBERG. In your comparison with PSRO, are you suggesting that the PSRO organizations are accountable to those they are reviewing?

Dr. CUSTIS. I'm not sure I understood.

Mr. STEINBERG. You referred to PSRO as an acceptable mechanism of peer review about which, as far as I understand, there is no dispute whatsoever that persons with the qualifications to review quality of care or professional competence issues, should review such issues.

The question is, to whom are those reviewers ultimately responsible? In the case of PSRO's, are they not ultimately responsible to

the individual hospital whose performance or physician whose performance that they may be reviewing, isn't that correct?

Dr. CUSTIS. What I was referring to was that in reviewing professional performance, it is given to professionals to do so.

Mr. STEINBERG. I don't believe there is any dispute with respect to that point.

Dr. CUSTIS. That was the extent of my reference. We incidentally, Mr. Steinberg, have a counterpart as you well know, in our HSRO and also in Central Office in DM&S, as an ongoing professional audit in the form of SERP, Systematic External Review Program.

An addition to that ongoing medical audit and also the use of Joint Commission Hospital Accreditation review, namely the use of a medical inspector, would be to provide on an ad hoc basis an authority to look into individual problems as they come to the attention of the Inspector General and to work with the Inspector General in this regard.

Mr. STEINBERG. Mr. Reynolds indicated that, according to his understanding, in the more notorious instances of allegations of inappropriate quality of care or inappropriate professional conduct that you would be likely to bring in outside reviewers to deal with that matter. Would you comment on that?

Dr. CUSTIS. Only to say that that is exactly right, we would do exactly that and we have done exactly that. It is a time-honored option that is used.

Mr. STEINBERG. How much money would you identify in fiscal 1981 as being available to you for that purpose, in terms of your budget request?

Dr. CUSTIS. I don't see that we would identify any additional money for this purpose. This is an ongoing expense we have had and we will continue to have and it is in our MAMOE appropriation.

Mr. STEINBERG. You suggest that the office you would set up is already in existence?

Dr. CUSTIS. I thought you were referring to the use of outside consultants. No, the office we will set up will be quite small and distinct from the SERP office that already exists. It will have approximately three, or at the most, four people and will use field health professionals on an ad hoc basis or a team approach to specific problems.

Mr. STEINBERG. Which is the way the SERP operates, does it not?

Dr. CUSTIS. Except it will not duplicate SERP operation. Yes, the ad hoc team approach is the SERP methodology.

Mr. STEINBERG. Am I correct in understanding your statement about contracting resources to mean that since you already do contract for matters of that degree of urgency, you would therefore need no additional resources to continue that?

Dr. CUSTIS. That is right.

Mr. STEINBERG. Although that contracting now might fall under the Office of Medical Inspector?

Dr. CUSTIS. Right.

Mr. STEINBERG. To whom would the head of that office report?

Dr. CUSTIS. To the Chief Medical Director and then to the Administrator, in turn reporting to the Inspector General.

Mr. STEINBERG. Do you believe there are ways the Inspector General and his investigations and audits have been helpful to you in carrying out your responsibility for administering the Department of Medicine and Surgery?

Dr. CUSTIS. I can think of numerous instances where it has been helpful. The one I am most pleased with and appreciative of is their work in risk analysis and review of pharmacy efficiency.

Mr. STEINBERG. Other than the questions of quality of care and professional competence, are there other existing problems between you and the Inspector General insofar as the conduct of audits and investigations?

Dr. CUSTIS. The testimony you have heard, Mr. Steinberg, from Dr. Cooper and the physicians representing hospitals and affiliate schools has been of concern to us also. I would hope that calling attention to this can be a constructive thing and that we can achieve a methodology in which this disruption can be properly handled.

I think, I really believe that the IG staff is much more sensitive and much more capable today than just a year ago. I think their educational effort, their experience, will continue and I think the time will come when this sort of turbulence that has been visited upon the professional staffs of our hospitals and school faculties will be a thing of the past; it simply must be.

Mr. STEINBERG. Were you consulted by the Inspector General in the recommendations that have been made with respect to time-keeping accountability procedures?

Dr. CUSTIS. Yes, sir. There has been an extensive amount of consultation going on in that direction and I believe we are just about ready to find the ultimate solution that will be acceptable to all concerned.

Mr. STEINBERG. That will be a solution that you believe will meet the concerns both of part-time physicians and of the Inspector General?

Dr. CUSTIS. I feel very confident about it, I think it will.

Mr. STEINBERG. Do you have any timetable as to when that might reach culmination?

Mr. WILSON. Very soon, Mr. Steinberg.

Mr. STEINBERG. If you would, for this hearing record, submit that when it is agreed to, we would very much appreciate it.

Are you aware, Dr. Custis, of any instances where an IG investigation at one of your facilities has substantially interfered with patient care or has had a harmful effect on a particular VA patient?

Dr. CUSTIS. I would preface my answer by saying in the last analysis, I think it's a matter of judgment. In my judgment, from what I have learned by way of reporting and followup review, I do not believe there has been any instance of compromise of patient care.

There has been a compromise of staff work efficiency but I believe there has been no patient suffering from this.

Mr. STEINBERG. Have there been substantial impairments of your affiliation relationships?

Dr. CUSTIS. There have been very serious threats regarding affiliation relationships that call for a lot of attention, a lot of fence

building. I think there is nothing that has happened that is irreparable.

Mr. STEINBERG. Have you personally had many discussions with deans of affiliated medical schools?

Dr. CUSTIS. I have had many discussions.

Mr. STEINBERG. What type of particular concerns did they raise with you? Were they the types of concerns we heard this morning with respect to the attitudinal problems on the part of investigators?

Dr. CUSTIS. Attitudinal problems and also, I think there is a large element of mutual misunderstanding of roles. The physician suffers very poorly lay surveillance, and yet there will be more and more of it, there is no doubt about it.

I think on the other hand the lay surveyor has got to appreciate this sensitivity and do his job without being so disruptive.

Mr. STEINBERG. In those discussions with medical school deans and other medical school officials, did you discuss with them the purpose and particular mission of the Inspector General and the importance of that responsibility?

Dr. CUSTIS. Yes, sir.

Mr. STEINBERG. Was that of any assistance to you in dealing with their concerns?

Dr. CUSTIS. In some cases, a great deal and in other cases, emotions were pretty high.

Mr. STEINBERG. Do you believe much of the problem is a question of misunderstanding and confusion as to what might properly be considered VA business and what might properly be considered medical school business and what might properly be considered personal business? If so, are there guidelines that can be helpful in that regard or actions Mr. Reynolds can take that can help ameliorate some of these problems?

Dr. CUSTIS. I think there is an element of that, yes. I think there are guidelines that can be clarified to better define those relationships.

Mr. STEINBERG. At some point, I would suppose there would have to be some differences of opinion on those issues as between employees of his office and perhaps employees of your office or yourself?

Dr. CUSTIS. That's right.

Mr. STEINBERG. Do you anticipate issuing any clarifications of what actions by physicians are properly considered VA activities and what actions are properly considered medical school activities? For example, if an individual attends a particular conference and he is a five-eighths individual, is his attendance at that conference five-eighths on behalf of VA and three-eighths on behalf of the medical school or solely on behalf of the medical school? Is that an issue we should concern ourselves with?

Dr. CUSTIS. I think that is an issue much too miniscule to be concerned with.

Mr. STEINBERG. Have people been concerned with issues like that?

Dr. CUSTIS. I think commonsense should prevail. There is not a physician on a staff of an affiliated hospital that is not heavily involved in education simultaneous with patient care. To try to be

overzealous in defining where one begins and one leaves off can be very disruptive. I think there must be deference given to the physician's judgment in these things. For the Central Office to do that kind of regulating, I think would be most unfortunate.

Mr. STEINBERG. In your opinion, have inquiries with respect to part time employees focused on areas you consider to be insignificant?

Dr. CUSTIS. I think there has been a variety. There have been insignificant things, there have been things based on misinformation, perceptions that are not real and there have been valid substantiated complaints. We have had the whole spectrum.

Mr. STEINBERG. What objections would you have to the Inspector General himself establishing a medical unit on his staff to carry out these investigations regarding quality of care and professional competence?

Dr. CUSTIS. I simply don't think as a corporate entity that's the place to put it. I don't think it would be as well received coming from there. I think the cooperation would be much more difficult to achieve from all hands. I think it would be difficult to maintain a full time staffing of such a division of the Inspector General.

I think finally that it is a misplaced prerogative. I think it is properly placed where it is, under the authority of the Chief Medical Director.

Mr. STEINBERG. If he were able to hire competent individuals and retain them in his office for performance of this task, you would still believe it would be preferable for those investigators to be accountable to the head of the Department of Medicine and Surgery?

Dr. CUSTIS. I strongly believe that.

Mr. STEINBERG. Do you concur in Mr. Reynolds' assessment that on matters brought to his attention as the Inspector General that he would have the final disposition in determining whose jurisdiction particular complaints would fall into?

Dr. CUSTIS. I have respect and faith in his judgment that he would exercise this properly. I can understand how his successor might not enjoy the degree of confidence that I have in him and vice versa.

Mr. WILSON. I didn't know he was leaving. [Laughter.]

Mr. STEINBERG. All of our plans for longevity at this point are somewhat tenuous and tentative. Would you agree without regard to how he would exercise that responsibility, that if a complaint were made to him as the Inspector General, under the Inspector General Act of 1978, it would be his decision as to whether a matter is related solely to patient care—and was therefore within the province of the office you are contemplating creating or whether there were mixed responsibilities or whether it did not relate to those matters and hence were his to investigate solely?

Dr. CUSTIS. Mr. Steinberg, are you trying to provoke an argument between the Inspector General and me? [Laughter.]

Mr. STEINBERG. I'm trying to determine whether or not the Inspector General will have the degree of independence that was contemplated in the establishment of his office if he cannot determine what matters properly fall within his jurisdiction. Many

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people would say that, a priority, from the outset, his integrity and objectivity and independence has been compromised.

Dr. CUSTIS. Let me answer this way. I am in no position to challenge what his prerogatives are in terms of what is or is not an example of something he should investigate. On the other hand, I think we have mutual respect for each other and where I should disagree with him, I am sure I would get a fair hearing from him.

Mr. STEINBERG. Mr. Wilson, do you have any comments on that?

Mr. WILSON. No, I think the Inspector General would exercise sound judgment in that regard with respect to a quality of medical care situation. He always has and I believe he will continue.

Mr. STEINBERG. Dr. Custis, according to the Inspector General's Semi-Annual Report No. 3—9 out of 10 sustained patient abuse allegations at the VA Medical Center at Waco, Tex., resulted in a minimum recommended punishment or less.

That report seems to raise questions as to whether the disciplinary actions have reflected a sufficiently strong antiabuse policy or would serve as deterrents to repeated abuses. Do you have any comments on that?

Mr. WILSON. Mr. Steinberg, may I—interrupt for a moment? Would you favor Dr. Custis answering that question generally as opposed to specifically with regard to the employees at Waco because they have rights concerning filing of things?

Mr. STEINBERG. Sure.

Dr. CUSTIS. I would only say in reviewing such decisions, every effort is made in that review to be quite sure that it is based on good evidence and that good judgment has been brought to bear. Otherwise, it is not concurred in.

Mr. STEINBERG. One of the matters you are concerned about, as well as individual fairness, is preventing repetitions of patient abuse, is it not?

Dr. CUSTIS. That's right. I would also say, however, that in a system this large, with the problems in the management of disturbed patients particularly, that human nature being what it is, we will always have these problems to handle.

Mr. STEINBERG. Mr. Hagen, if we can turn to the Department of Veterans' Benefits for a moment or two, would you comment generally on the relationship which exists between your Department and the Inspector General's Office?

Mr. HAGAN. We have a satisfactory relationship between the Department of Veterans' Benefits and the Office of the Inspector General. Since January 1, 1970, they have conducted about 23 audits of our office. From the beginning, the relationship has been one of full cooperation.

However, at the early stages of the Inspector General's operation, we did find some problems with the technical expertise of the people doing the audits. At the close of each audit, the director at the field station is given an opportunity to discuss what the findings are.

We have been able to resolve a number of these issues. As his auditors have developed expertise, we have found this to be less and less of a problem. Some of the directors do feel that our own surveys have more impact on the management of their programs than those of the Inspector General's Office.

On the whole, we are satisfied with the operation of the office.

Mr. STEINBERG. Would you say that his office has helped you in your responsibilities in managing the Department of Veterans' Benefits?

Mr. HAGAN. They have made us more sensitive to problems that can develop in regional offices. The people, knowing there is a possibility that there will be a followup on recommendations on things we have been alerted to, are more responsive, more aware of what is going on and tend to be more observant.

Mr. STEINBERG. Are not their recommendations of assistance?

Mr. HAGAN. Yes.

Mr. STEINBERG. Have you had specific problems with many of their recommendations?

Mr. HAGAN. No, we have not had any problems. At the time of close-out, the Director sits with the audit team and goes over the recommendations. If there are any issues that cannot be resolved, they are usually referred to the Department of Veterans' Benefits here in the Central Office. There we join issues and work out a common solution.

Mr. STEINBERG. Do you and the Chief Benefits Director meet with Mr. Reynolds or his designees on a frequent basis?

Mr. HAGAN. We do meet with Mr. Reynolds and we meet with his regional people. At times, some of our area field directors are present when the audit entrance interview is held and also for the exit interview. Due to a need to conserve travel funds, we have not been able to do this as often as we would like but it is something we have done.

Mr. STEINBERG. Do you think there are any areas today where the Inspector General's Office lacks the proper expertise to conduct an adequate investigation in your Department?

Mr. HAGAN. No, I do not believe so.

Mr. STEINBERG. There is an Inspector General draft audit report that notes that 58 percent of educational assistance overpayments are attributable to delays by veteran beneficiaries and educational institutions in reporting terminations or reduced training time.

We understand that a new policy directive is in preparation on that particular point. It would be very helpful to the committee to have an opportunity to review a draft of that new issuance when it is ready and we would appreciate it if you could provide that opportunity prior to its final publication.

Mr. HAGAN. I will see that it is done.

Mr. STEINBERG. Thank you. Finally, could you provide for the record, unless you know it now, what is the total dollar amount of pension overpayments that has been waived by the agency?

Mr. HAGAN. I cannot give you that at this time, but I will provide it for the record.

[Subsequently, the Veterans' Administration submitted the following information:]

We were asked to furnish the numbers of station actions taken by the Committee on Waivers on Compensation and Pension Sections. The Controller has furnished the following information:

Fiscal year 1980 from Oct. 1, 1979 to Mar. 31, 1980

Cases waived	3,295
Amount waived	$7,481,788

Controller advised there is no separate breakout available for pension alone.

Mr. STEINBERG. That concludes our questions. Mr. Wilson, you seem to have a comment?

Mr. WILSON. No.

Mr. STEINBERG. We feel that the presence of each of you here today has been very valuable from our standpoint in our understanding and, hopefully, the public's understanding of the relationships—some most complicated and sensitive ones—that must exist between a function like the Inspector General's function and the leadership and policymaking functions in the agency.

We thank you for sharing with us such a very long morning and early afternoon. I think it is a tribute to the high regard the agency has for Mr. Reynolds and for his mission which he has—to improve the agency's effectiveness and efficiency and to ferret out, where it may exist, abuses and fraud—that you have all shown this interest by appearing here this morning and we are very grateful.

Would you please convey to the Administrator our thanks for your forebearance?

Mr. WILSON. I certainly will, Mr. Steinberg, and may I express my appreciation to the Committee and particularly the chairman, Senator Cranston, who has been extremely helpful to us.

Mr. STEINBERG. We will certainly pass that along and, finally, we will get Mr. Reynolds back for a few last words of closing.

Mr. Reynolds, would you like generally to make any responses to the statements of Dr. Cooper, Dr. Tisi, and Dr. Bailey?

Mr. REYNOLDS. I would like to make a general statement. The general questions that have been raised, although I do not agree with some of the specifics, we are certainly aware of and we have not been ignoring them. Aside from the medical inspector thing, when we have had complaints, we have investigated to find out about the conduct of our investigators and whether we have had a problem or not.

On occasion, we have had that in audit also, but more frequently in investigations. I met last summer with about two-thirds of the hospital directors to discuss our program and our activities and how we do business and so forth.

I have met with Dr. Cooper previously and we shared information about Manhattan which was an early source of some rather strong complaints. I and my principal assistants and other senior staff have met with deans, chiefs of staff, et cetera, at medical schools and colleges where there have been such complaints and gone over the material with them.

We have been reaching more and more doctors, particularly through the efforts of my assistant for audit, through the regional medical education center programs. I don't mean to suggest that we have covered the waterfront or gotten our explanations and our concerns and the propriety of what they should expect and what they should not expect and so forth across to the medical profession as a whole, I don't think we have succeeded in doing that as yet, but we are trying to and continue to try to do so.

I don't know how far you want to go into specifics versus responses for the record.

Mr. STEINBERG. It might be preferable, if you wish, if you responded specifically for the record after you have had an opportunity to study it. Whatever form you choose would be fine with us.

[Subsequently, the Office of the Inspector General submitted the following information:]

We would like to respond for the record to the views of the panel of physicians on the manner in which we conduct investigations involving physicians and the alleged adverse effects on the relationship between VA Medical Centers and affiliated Medical Schools.

While we will respond to specific complaints, we would first like to address certain common concerns which have been expressed by the panel and/or others. It should be first noted, however, that the procedures that we follow are in accordance with those generally followed by other federal investigative agencies.

1. Physicians should be advised of their rights.

Response: Although it is not clear to us in what manner some physicians believe that their rights are being violated, it appears that they are of the opinion that they should be advised of their Miranda rights at the commencement of the investigation or, at least, when they are interviewed by one of our investigators. It should first be noted that the Supreme Court has decided in several recent cases and the Department of Justice has advised us that the use of the Miranda warnings is required only in custodial situations. None of our investigations to date have involved custodial situations. We do, however, on a case-by-case basis, give the Miranda warning to the subject(s) of the investigation when the circumstances warrant it.

It may be, however, that the real concern being expressed by these physicians is that they are unaware of their rights, particularly their right to counsel, and, therefore, when interviewed by a VA investigator, they erroneously believe that the investigator is acting improperly. We are exploring the possibilities of advising all VA physicians, including

part-time physicians, of their rights through some additional form of written communication. We believe that this will alleviate some of the concerns expressed at these hearings. We are also asked to address the pros and cons of the VA investigator advising all witnesses of their rights at the commencement of an investigation. We agree that all VA employees should be aware of their rights and would note that these rights are set forth in VA Manual MP-1, Par. I, Chapter 2, par. 204.07. Whether VA employees, including part-time physicians, are aware of these rights as set forth in these manuals will have to be reviewed.

We would not agree, however, that all witnesses, including subjects who do not meet the criteria set forth above, should be advised of the full Miranda rights, including the right to counsel, during an interview. The giving of such rights to all witnesses where not required will have the effect of "chilling" the investigation and prevent the obtaining of information. Moreover, the giving of these rights to all witnesses will only serve to confuse the witnesses and create unnecessary mental anguish as to their status in the context of the investigation. In addition, the giving of rights to all witnesses may well have the counterproductive effect of making the subject of the investigation less attentive to his/her rights when given. It could have the effect of making the giving of such rights a meaningless formality if given indiscriminately to all witnesses.

2. Physicians under investigation should be interviewed at the beginning of the investigation

Response: The point in time at which the subject of an investigation is contacted varies depending on the nature of the investigation. At such

time as we are satisfied it will not jeopardize the conduct of the investigation, the subject may be contacted and advised of the nature of the allegation. We are concerned that premature contact could result in interference with the investigation, coaching or intimidating of witnesses or screening or altering records and or other evidence. Normally, a full interview with the subject takes place after complete development of information bearing on the issue. At that time the subject will have the opportunity to be aware of each allegation and be given full opportunity to respond.

3. Physicians are told that they must cooperate in VA investigations or face possible disciplinary action and that they are not to discuss their testimony with others.

Response: These are requirements that have been in existence for many years for all employees, including physicians, in the Veterans Administration, and have been concurred in by our Office of Personnel and General Counsel. These requirements are set forth in 38 CFR 0.735-21, Standards of Conduct in Special Areas and 38 CFR 1.454, Unauthorized Discussion of Investigative Information. Our primary purpose in instructing witnesses not to discuss the investigation is to, as much as possible, contain knowledge of the investigation and prevent the spreading of information, rumor and gossip which could seriously damage the reputation of individuals and have an adverse effect on the operation of a station. It also helps to preclude the altering or distortion of information from subsequent witnesses. Moreover, witnesses subordinate to the individual under investigation need this instruction as protection from possible attempts by their supervisor to intimidate them and to learn the content of their testimony.

Dr. Cooper of the Association of American Medical Colleges raised the following additional points but did not cite the specific instances in which these problems appeared to have occurred:

1. Medical staff should be permitted to have counsel present during interview by Inspector General personnel.

Response: It has been our long-standing policy that a witness may have counsel present and we are unaware of any instance when this right has been denied. However, based on concerns expressed in this hearing, we are reviewing our procedures with a view to taking more positive steps to assure that witnesses are fully aware of this policy.

2. Individuals interviewed should be permitted access to reports or notes of interview to verify their accuracy.

Response: Any interview of substance in an investigation is taken down as recorded verbatim question and answer testimony or reduced to a narrative affidavit. Except on a few occasions when recorded testimony may be transcribed after an investigator has left the station, the witness is given full opportunity to review the statement and make any desired corrections, additions, or clarifications before signing. Also, he is provided a copy of the statement, if he requests it.

3. Inspector General staff do not have the qualifications to enable them to intelligently perform an adequate investigation of professional activity related to provisions of health care.

Response: We are uncertain of the exact scope of activity intended in the words, "professional activity." We recognize that we do not have staff qualified to evaluate medical care delivery and related professional medical judgments. We do not believe our investigative reports show such activities

by our investigators. We have reviewed medical activities, in both our audits and investigations, for proper compliance with procedures established by the Department of Medicine and Surgery to control the quality of medical care delivery. We believe such reviews are within our expertise and our statutory responsibilities.

Dr. Joseph P. Bailey, Dean for Clinical Sciences, Medical College of Georgia, alleged that the Inspector General investigator who conducted our recent investigation at the VA Medical Center, Augusta, Georgia, was heavy-handed, dealt with clinical operation of DM&S, had no understanding of the working relationship between the VAMC and the School of Medicine and his activities placed the relationship between the VAMC and Medical School in jeopardy.

In prior testimony before your Committee on April 18, 1980, Dr. Joseph W. Rubin, a part-time thoracic surgeon at the VA Medical Center, Augusta, additionally complained that his personal experience in the investigation was traumatic in that unfounded allegations were leveled at him during the investigation; that the investigator interfered with patient management and that as a result of the investigation VA officials have sought to curtail the Medical College of Georgia's telephonic surveillance of VAMC pacemaker patients.

Our investigation at VAMC Augusta was initiated at the specific request of Senator Richard Stone to whom allegations had been made of conflict of interest on the part of Dr. Rubin in the operation of a pacemaker monitoring service involving veteran patients. The investigator assigned to the case is a very experienced and tactful investigator who has since been appointed Director of our Washington Field Office of Investigations. We have carefully reviewed the conduct of the investigation with the investigator and are fully satisfied that it was well conducted. During the investigation the investigator became sufficiently concerned over the attitude and behavior of Dr. Rubin to consult with the VAMC Director and Chief of Staff, both of whom advised him that he had proceeded appropriately.

We would be very pleased to make a copy of the investigation report, including all supporting testimony and exhibits, available for the Committee to review. This would include the question and answer testimony of Dr. Rubin. This material will fully set forth the steps taken in the investigation to include what witnesses were asked and which records were reviewed. We believe the report will clearly show that there was no heavy-handedness; that only that investigation necessary to fully develop the facts pertaining to the specific allegation was conducted; that it did not involve itself in clinical matters or interfere with patient management; that the investigator did, in fact, develop a very good understanding of the local relationship between the VAMC and the Medical School, specifically as it related to the pacemaker follow-up issue; and that the interview with Dr. Rubin was very well conducted. Our investigation found that Dr. Rubin was not involved in a conflict of interest. Concerning the possible curtailment of telephonic surveillance of pacemaker patients by the Medical College of Georgia, we drew no conclusions relative to this in our report and made no recommendations whatsoever.

We would like to address the complaints of Dr. Gennaro Tisi as set forth in his letter to the Chairman dated June 2, 1980.

Our investigation at San Diego involved allegations contained in an anonymous letter that Dr. Tisi and two employees of the Pulmonary Function Section were misusing a VA computer for a private business. The allegations were not sustained.

We became aware of Dr. Tisi's complaints in early May and immediately sent the Deputy Assistant Inspector General for Investigations from Washington and the Director of the Los Angeles Field Office of Investigations to San Diego to look into his allegations. They met with Dr. Tisi, VA Medical Center and medical school officials and witnesses involved in the investigation on May 12-14. Dr. Tisi's complaints then were essentially as set forth in his June 2 letter and in his oral testimony before the Committee. The following is a summary of Dr. Tisi's most significant complaints and our comments. We will not comment again on any complaints concerning our policies which have previously been covered in testimony.

1. Dr. Tisi said that on first contact with the investigator that "he flashed his badge, gave me his name and proceeded to interrogate me." Response: The investigators of this office do not carry badges. During our investigation of these complaints, Dr. Tisi acknowledged that what he was shown was our investigator's credential and he had full opportunity to read it.

2. Dr. Tisi complained that the investigation involved itself in the VAMC/medical school affiliation. Further, he complained that our inquiry into his sabbatical leave and preparation of a textbook was repugnant and revolting. He perceived our investigation as "an incredible potential loss to the university and VA."

Response: We wish to put this matter into proper focus. During the investigation a university secretary alleged that she and the VA secretary had performed considerable non-VA typing for Dr. Tisi during duty hours for which they were paid by a publishing company. Since this matter was not within the scope of the ongoing investigation, the investigator contacted his supervisor for instructions. He was told to interview the VA secretary and a determination could then be made as to whether the matter would be further pursued. The investigator interviewed the VA secretary concerning the circumstances of her performing the non-VA typing for Dr. Tisi and the effect this might have upon her assigned duties. That was the total extent of our involvement in this matter. We did not further pursue it.

4. Dr. Tisi alleged that during the interview with the above VA secretary, she was threatened with imprisonment by the investigator.

Response: She since has denied that she was in any way threatened by the investigator although she was concerned over the information she was furnishing.

4. Dr. Tisi alleged that the investigator rifled through his files in his office giving the impression he had no right to refuse and that drawers were opened that contained patients' privileged information and his own health and academic records.

Response: The investigator wished to look for computer printouts. He first inspected the office of one of the technicians who was not on duty. Dr. Tisi personally unlocked the office for the investigator and participated with the investigator in the inspection of that office. Dr. Tisi personally opened the desk drawers of the employee, something which we would not do.

Dr. Tisi then volunteered to have his office inspected although he well may have felt, as he states, that he had no right to refuse. He was present with the investigator throughout this inspection. The investigator was interested specifically in computer printouts and tapes and had no interest in any patient or other records nor did he examine any.

5. Dr. Tisi and others indicated that during interviews they were not initially advised of the nature of the investigation.

Response: We have found that this had not been immediately done in each instance and the investigator has been counseled concerning this. It should be noted that Dr. Tisi was advised of the nature of the investigation within twenty to thirty minutes after the interview commenced. The initial period of time consisted of "small talk" and did not include any substantive matters.

6. Dr. Tisi complained of "goon-like tactics."

Response: We re-interviewed most of the witnesses contacted by the investigator and received no significant complaints concerning his demeanor or conduct, other than from Dr. Tisi.

The Committee had also received a prior complaint from the dean of the medical school at San Diego which we looked into and provided a report on. That complaint concerned some of our policies which we have previously discussed.

It was brought out in the course of the hearing that complaints had been received from four medical schools. We believe that in addition to San Diego and Augusta, this reference may have been to investigations we conducted at the VA Medical Center, Denver and the VA Medical Center, Manhattan. In both instances we were satisfied that the complaints were without merit. If the Committee desires, we will be pleased to provide copies of these investigation reports and full accounts of the complaints. However, we would like to comment briefly now on the Denver investigation since, in our opinion, it initiated and contributed very significantly to a present nationwide misconception in the medical community that our investigators are "Gestapo-like" and that we employ various offensive and inappropriate investigative techniques.

While it is not uncommon for an individual under investigation to attempt to discredit the investigator and the investigation, we found that the physician under investigation in Denver did this to a greater extent than we have previously experienced. Through professional colleagues and members of Congress, he spread throughout the medical community nationwide untrue and distorted information concerning our investigative techniques which was accepted at face value. It should be noted that based on our investigation the Chief Medical Director determined that the doctor should be removed from VA employment, however, he resigned.

Although the Office of Inspector General is new in the VA, the Office of Investigations is not. Our investigative staff has been conducting investigations for many years and the basic investigative policies and procedures have remained essentially the same since creation of the Office of Inspector General. It should be noted that in the last five years we have conducted more than 40 investigations of physicians involved in a wide variety of alleged irregularities without significant complaints or concerns expressed by the medical community until this year.

Regardless of the merits of the specific complaints we have discussed, we are very concerned over the medical community's present perception of the manner in which we conduct investigations. We are well aware of the devastating effect an investigation can have on the operation of a station and the personal reputation of individuals.

To date, we have taken the following steps to deal with complaints, promote a better understanding of how we conduct investigations and assure investigations are properly conducted.

1. Depending on the nature of the complaints we have conducted investigations of allegations relative to the conduct of our investigators.

2. The Inspector General or members of his key staff have met with deans of medical schools, top officials in the Department of Medicine and Surgery and VA Medical Center officials.

3. A memorandum has been issued to all investigative personnel reminding them of their responsibilities concerning the manner in which investigations are conducted.

4. Investigative supervisors have been directed to meet individually with each investigator and thoroughly review what is expected of the investigator in the conduct of the investigation.

We expect our investigations to be conducted discretely and tactfully with as little disruption as possible to normal hospital activities consistent with the need to handle investigations completely and expeditiously. We recognize that there can be abuses and misunderstandings and we have strongly urged that the officials with whom we have met encourage the prompt referral of any complaints to us. We have also asked these officials to try to promote a better understanding in the medical community of how we operate.

We wish to reemphasize that we fully recognize that we are not qualified to look into or form judgments in purely professional matters. It is our long-standing policy that when professional judgments are involved, we obtain professional assistance or turn the matter over to professionals for handling, depending on the circumstances of the case.

Mr. REYNOLDS. There is one point I would not like to leave unanswered even for a period of time. My best information on the computer situation at San Diego was that our auditor and investigator working on that job cleared access to the computer as was described with the hospital director but more specifically with the individual responsible for the computer operation.

There was no patient activity going on, and we were told we could in fact access the computer at that time. We did not operate the computer, it was operated by the computer technicians there. As has been said, we could have waited until 5 o'clock or midnight. The problem with the allegations was that we would not provide the opportunity to take routine information off the computer.

The allegations had to do with what the computer was being used for and it was therefore necessary—the term "sneak attack" was used, but in point of fact to resolve the allegations, it was necessary to take immediate control of the situation in order to preclude someone from manipulating the computer.

This process cleared the individual, whereas otherwise if the opportunity had been provided to in fact manipulate the computer, you never could have said one way or another whether the allegation was valid or invalid.

Mr. STEINBERG. Would you provide for the record specific documentation that the access to the computer was authorized by the appropriate people in the hospital?

Mr. REYNOLDS. I can give you testimony to that effect, I don't have a signed document.

Mr. STEINBERG. I would think you would just like to name the persons and, according to the notes of your investigators, the time at which the permission was granted.

Mr. REYNOLDS. I can do so.

[Subsequently, the Office of the Inspector General submitted the following information:]

Concerning access to the computer at VAMC San Diego, our investigator and the auditor who accompanied him provided us with the following information:

At the outset of the investigation, Dr. John Ditzler, the VAMC Director, was aware of the investigator's intent to determine what was on the computer and cautioned him to be very careful not to dump any patient information from the computer. When the investigator and auditor wanted to make this unannounced review of what was on the computer, Thomas DeGraff, Supervisory Medical Technician who operated the computer, was contacted in the absence of Dr. Tisi. The technician was questioned closely by the investigator and auditor and he assured them that nothing was being processed or planned at that time and that shutting down the computer would have absolutely no effect on pulmonary operations or patient care. This computer is not used to monitor patients. The total down time relating to our investigation was two to two and one-half hours. We are aware that this information is in direct conflict to that provided by the technician in his letter to the Chairman, dated June 30, 1980. It should be noted, however, that when interviewed by the Deputy Assistant Inspector General for Investigations and the Director, Los Angeles Field Office of Investigations in May, the technician voiced no concern over any effect on patient care and stated that the investigator and auditor may have asked permission to dump the computer but he could not recall.

Mr. STEINBERG. There have been a couple of references in the testimony to people being cleared or being exonerated and, with respect to Dr. Bailey's testimony, to the fact that a letter of exoneration had to be forcibly extracted from the appropriate people. Do you have a policy in that regard?

Mr. REYNOLDS. I'm afraid we don't apparently. We looked at it from my office's standpoint that we report positive and negative findings to the department and staff offices where the employee works. We make recommendations for appropriate disciplinary action or other corrective actions needed.

I guess we operated on the assumption that if our findings were that the charges were unfounded, the department, just as when it presented the disciplinary action letter when the charges were founded, would advise the individual. It appears that that's a little loose and needs to be tightened up. Either the departments have to notify the individual or we have to do it, but it certainly has to be done.

Mr. STEINBERG. It might be most advantageous coming from you. Of course, everyone has to be careful of how a document is worded, but obviously the appearance of one of your investigators at a hospital, for example, would be of grave personal concern to an individual.

Many individuals inevitably become aware in the process of an investigation that an individual was the subject of an investigation, and even though ultimately the system might learn in a very impersonal way that that individual had been cleared by your investigation, having something in hand to that effect would be most reassuring not only to that individual but to other individuals that the system was fair and was concerned about the reputation of employees in the system.

If you would consider whether a policy on that is appropriate and let us know, that would be very helpful. It was suggested in Dr. Cooper's, Dr. Bailey's, and Dr. Tisi's testimony that your investigators are not fully apprised and do not fully understand the nature of affiliation arrangements, their value, purpose, and history.

Do you believe that to be the case?

Mr. REYNOLDS. Again, I cannot totally generalize to a yes or no. We have a lot of investigators that have such familiarity and we have others who are new to us and doubtlessly are not as sensitive, not as familiar yet as we need to make them. You have two situations really between San Diego and Augusta.

In the Augusta situation, we sent one of our most experienced investigators, an individual who has had a very, very good track record and a lot of compliments on how he conducts investigations. I might mention when an investigator finishes an interview, one of the more common things he does, particularly if there is any showing of concern or animosity toward the interviewer is to give the interviewee on the record an opportunity to express any concern about the conduct of the interview. We do use that approach.

In San Diego, we had an investigator with quite a few years of experience but relatively new to us.

[Subsequently, the Office of the Inspector General submitted the following information:]

With regard to the request that we consider a policy of advising the subject of an investigation when allegations against him have not been sustained by investigation, this should be accomplished by the appropriate VA department or staff office to which we submit our investigation report. We will establish a procedure to assure that this is done.

Mr. STEINBERG. One of the most commonly cited reasons for individuals feeling intimidated by investigators is the statement that you should not discuss your testimony with anyone else. Is it possible that a little more explanation to individuals as to why that is important in terms of protecting the civil rights of individuals would be useful and that you could help develop procedures that might entail less adverse fallout from that kind of admonition?

Mr. REYNOLDS. We can try. I don't think we have 100 percent adverse fallout on that issue. Some resent it, others understand it readily. To some we would have to say the reason we are doing this is because we don't want you to try to influence the testimony of subordinates. More often, we get the complaint, you told my subordinates they can't tell me.

It's going to get a little more abrasive, we are going to be saying we don't want you to influence the testimony of your subordinates. We'll see what we can do but we're walking through a little bit——

Mr. STEINBERG. There are inevitable conflicts and they can't be papered over.

Mr. REYNOLDS. Yes, there are.

Mr. STEINBERG. Do you have any set criteria that you use for differentiating between what is a VA function and what is a medical school function and therefore, for example, what functions a VA secretary can properly perform and what functions, in your view, she could not properly perform?

Mr. REYNOLDS. I don't know that we have any set criteria. We have to go to the affiliation agreement at a particular institution to understand exactly what the arrangements are. As a fundamental rule, a Government employee, using the secretary illustration, is there to do Government work and not other work.

You can get into splitting hairs. If you go to a convention, who are you working for? If you are going to a convention to present a paper, who are you representing and I don't think we've gotten down into that kind of hairsplitting at all.

Mr. STEINBERG. Would it be your view that if an individual is part time at the medical school and part time at the VA and the VA secretary provides services relating to the medical school, that that is not an appropriate use of a VA employee's time?

Mr. REYNOLDS. Yes, with a qualifier, substantial amount of time, lots of time being put in for the medical school.

Mr. STEINBERG. You think there is a rule of de minimis activities that should be followed?

Mr. REYNOLDS. Yes. Again, the practicalities of the fact that the doctor is carrying out three different jobs with some degree of overlap when he is at a particular location, the phone rings, it might be his private practice or the medical school or whatever. As we say, we are not trying to split hairs on it.

Mr. STEINBERG. That's a good example of a de minimis activity—not to have to screen the call to determine whether one is calling with respect to a medical school matter before you say hello. Perhaps, there might be other activities that might come within the category of de minimis and that might be something that might be helpful to you to evaluate in consultation with Dr. Custis and the staff of the Department of Medicine and Surgery so that people

don't feel unduly put upon or intimidated in the course of trying to live in a rather complicated relationship.

Every direction they turn involves problems. I guess the secretary seems to come up in Denver and it comes up in San Diego and other places. Thus, it might be helpful if there were some general guidelines so that people are assured that you are not nickel and dime-ing every activity of the secretary in the course of a given day.

I don't know how the guidelines should be drawn, but perhaps some efforts to articulate some would be reassuring and would help your investigators marshal their resources in a productive way.

Mr. REYNOLDS. Yes, I agree. The problem comes in when we receive an allegation that a secretary is spending a significant amount of her time on other than VA activity. In order to get at what she is actually doing, you end up looking at nickels and dimes to find out if it adds up to a lot of dollars or not. You don't totally avoid getting into that type of an issue as part of an investigative process.

Mr. STEINBERG. We will have a number of questions to submit for the record, believe it or not. We have restrained ourselves. We hope that the hearing has been useful for the agency, for your office, for the components of the agency that have the principal responsibility for administering programs and serving veterans and that it has been as valuable for them as it has been for us. I think we have learned a great deal.

There is a great deal of followup to be done on the matters discussed today and we look forward to a continuing exchange with you. If you can start to provide us with responses for the record as they become available, rather than wait and send everything at once because some of these matters will drag out over a period of weeks and months, we would very much appreciate it.

If you have no further comments, this hearing stands adjourned.

Mr. REYNOLDS. I would like to thank you very much.

[Whereupon, the hearing was adjourned at 2:05 p.m.]

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